

Introduced by Senator Speier

February 17, 2005

An act to amend Sections 1358.4, 1358.5, 1358.6, 1358.8, 1358.9, 1358.10, 1358.11, 1358.14, 1358.15, 1358.17, 1358.18, 1358.20, and 1358.21 of, and to repeal and add Section 1358.12 of, the Health and Safety Code, and to amend Sections 10192.4, 10192.5, 10192.6, 10192.8, 10192.9, 10192.10, 10192.11, 10192.14, 10192.15, 10192.17, 10192.18, 10192.20, and 10192.21 of, and to repeal and add Section 10192.12 of, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 375, as introduced, Speier. Medicare supplement coverage.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a violation of the act a crime. Existing law provides for the licensure and regulation of health insurers by the Department of Insurance. Under existing law, a plan or insurer that issues a Medicare supplement contract or policy, as defined, is required to comply with requirements in addition to those generally imposed on health care service plan contracts and health insurance policies.

This bill would make certain changes to these Medicare supplement coverage provisions corresponding to revisions made to the Medicare program by the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The bill would revise eligibility requirements for Medicare supplement coverage, including the guaranteed issue of coverage, and would add 2 benefit plans. The bill would also revise application procedures for this coverage.

Because a violation of the new requirements for Medicare supplement coverage issued by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1358.4 of the Health and Safety Code is
2 amended to read:

3 1358.4. ~~For~~ *The following definitions apply for the purposes*
4 ~~of this article, the following terms have the following meanings:~~

5 (a) “Applicant” means:

6 (1) An individual enrollee who seeks to contract for health
7 coverage, in the case of an individual Medicare supplement
8 contract.

9 (2) An enrollee who seeks to obtain health coverage through a
10 group, in the case of a group Medicare supplement contract.

11 (b) “Bankruptcy” means that situation in which a
12 ~~Medicare+Choice~~ *Medicare Advantage* organization that is not
13 an issuer has filed, or has had filed against it, a petition for
14 declaration of bankruptcy and has ceased doing business in the
15 state.

16 (c) “Continuous period of creditable coverage” means the
17 period during which an individual was covered by creditable
18 coverage, if during the period of the coverage the individual had
19 no breaks in coverage greater than 63 days.

20 (d) (1) “Creditable coverage” means, with respect to an
21 individual, coverage of the individual provided under any of the
22 following:

23 (A) Any individual or group contract, policy, certificate, or
24 program that is written or administered by a health care service
25 plan, ~~disability~~ *health* insurer, fraternal benefits society,
26 self-insured employer plan, or any other entity, in this state or

1 elsewhere, and that arranges or provides medical, hospital, and
2 surgical coverage not designed to supplement other private or
3 governmental plans. The term includes continuation or
4 conversion coverage.

5 (B) Part A or B of Title XVIII of the federal Social Security
6 Act (Medicare).

7 (C) Title XIX of the federal Social Security Act (medicaid),
8 other than coverage consisting solely of benefits under Section
9 1928 of that act.

10 (D) Chapter 55 of Title 10 of the United States Code
11 (CHAMPUS).

12 (E) A medical care program of the Indian Health Service or of
13 a tribal organization.

14 (F) A state health benefits risk pool.

15 (G) A health plan offered under Chapter 89 of Title 5 of the
16 United States Code (Federal Employees Health Benefits
17 Program).

18 (H) A public health plan as defined in federal regulations
19 authorized by Section 2701(c)(1)(I) of the federal Public Health
20 Service Act, as amended by Public Law 104-191, the federal
21 Health Insurance Portability and Accountability Act of 1996.

22 (I) A health benefit plan under Section 5(e) of the federal
23 Peace Corps Act (Section 2504(e) of Title 22 of the United States
24 Code).

25 (J) Any other publicly sponsored program, provided in this
26 state or elsewhere, of medical, hospital, and surgical care.

27 (K) Any other creditable coverage as defined by subsection (c)
28 of Section 2701 of Title XXVII of the federal Public Health
29 Services Act (42 U.S.C. Sec. 300gg(c)).

30 (2) "Creditable coverage" shall not include one or more, or
31 any combination of, the following:

32 (A) Coverage for accident-only or disability income insurance,
33 or any combination thereof.

34 (B) Coverage issued as a supplement to liability insurance.

35 (C) Liability insurance, including general liability insurance
36 and automobile liability insurance.

37 (D) Workers' compensation or similar insurance.

38 (E) Automobile medical payment insurance.

39 (F) Credit-only insurance.

40 (G) Coverage for onsite medical clinics.

(H) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) “Creditable coverage” shall not include the following benefits if they are provided under a separate policy, certificate, or contract or are otherwise not an integral part of the plan:

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Other similar, limited benefits as are specified in federal regulations.

(4) “Creditable coverage” shall not include the following benefits if offered as independent, noncoordinated benefits:

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(5) “Creditable coverage” shall not include the following if offered as a separate policy, certificate, or contract:

(A) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the federal Social Security Act.

(B) Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code.

(C) Similar supplemental coverage provided to coverage under a group health plan.

(e) “Employee welfare benefit plan” means a plan, fund, or program of employee benefits as defined in Section 1002 of Title 29 of the United States Code (Employee Retirement Income Security Act).

(f) “Insolvency” means when an issuer, licensed to transact the business of a health care service plan in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer’s state of domicile.

(g) “Issuer” means a health care service plan delivering, or issuing for delivery, Medicare supplement contracts in this state, but does not include entities subject to Article 6 (commencing with Section 10192.1) of Chapter 1 of Division 2 of the Insurance Code.

(h) “Medicare” means the federal Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

(i) ~~“Medicare+Choice”~~ “*Medicare Advantage Plan*” means a plan of coverage for health benefits under Medicare Part C and includes:

(1) Coordinated care plans that provide health care services, including, but not limited to, health care service plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organizations plans.

(2) Medical savings account plans coupled with a contribution into a ~~Medicare+Choice~~ *Medicare Advantage* medical savings account.

(3) ~~Medicare+Choice~~ — *Medicare Advantage* private fee-for-service plans.

(j) “Medicare supplement contract” means a group or individual plan contract of hospital and medical service associations or health care service plans, other than a contract issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C.A. Section 1395mm) or an issued contract under a demonstration project specified in Section 1395ss(g)(1) of Title 42 of the United States Code, ~~which~~ *that* is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare. “Contract” means “Medicare supplement contract,” unless the context requires otherwise. “*Medicare supplement contract*” *does not include a Medicare Advantage plan established under Medicare Part C, an outpatient prescription drug plan established under Medicare Part D, or a health care prepayment plan that provides benefits pursuant to an agreement under subparagraph (A) of paragraph (1) of subsection (a) of Section 1833 of the Social Security Act.*

(k) “Secretary” means the Secretary of the United States Department of Health and Human Services.

SEC. 2. Section 1358.5 of the Health and Safety Code is amended to read:

1358.5. (a) A contract shall not be advertised, solicited, or issued for delivery as a Medicare supplement contract unless the contract contains definitions or terms that conform to the requirements of this section.

(1) (A) “Accident,” “accidental injury,” or “accidental means” shall be defined to employ “result” language and shall not include words that establish an accidental means test or use words such as “external, violent, visible wounds” or other similar words of description or characterization.

(B) The definition shall not be more restrictive than the following: “injury or injuries for which benefits are provided means accidental bodily injury sustained by the covered person that is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while coverage is in force.”

(C) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers’ compensation, employer’s liability, or similar law, unless prohibited by law.

(2) “Benefit period” or “Medicare benefit period” shall not be defined more restrictively than as defined in the Medicare program.

(3) “Convalescent nursing home,” “extended care facility,” or “skilled nursing facility” shall not be defined more restrictively than as defined in the Medicare program.

(4) (A) “Health care expenses” means *for purposes of Section 1358.14*, expenses of health care service plans associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

~~(B) “Health care expenses” shall not include any of the following:~~

~~(i) Home office and overhead costs.~~

~~(ii) Advertising costs.~~

~~(iii) Commissions and other acquisition costs.~~

~~(iv) Taxes.~~

~~(v) Capital costs.~~

~~(vi) Administrative costs.~~

~~(vii) Claims processing costs.~~

(5) “Hospital” may be defined in relation to its status, facilities, and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

(6) “Medicare” shall be defined in the contract. “Medicare” may be substantially defined as “The Health Insurance for the

1 Aged Act, Title XVIII of the Social Security Amendments of
2 1965, as amended,” or “Title I, Part I of Public Law 89-97, as
3 enacted by the 89th Congress and popularly known as the Health
4 Insurance for the Aged Act, as amended,” or words of similar
5 import.

6 (7) “Medicare eligible expenses” shall mean expenses of the
7 kinds covered by Medicare *Parts A and B*, to the extent
8 recognized as reasonable and medically necessary by Medicare.

9 (8) “Physician” shall not be defined more restrictively than as
10 defined in the Medicare program.

11 (9) (A) “Sickness” shall not be defined more restrictively than
12 as follows: “sickness means illness or disease of an insured
13 person that first manifests itself after the effective date of
14 insurance and while the insurance is in force.”

15 (B) The definition may be further modified to exclude
16 sicknesses or diseases for which benefits are provided under any
17 workers’ compensation, occupational disease, employer’s
18 liability, or similar law.

19 (b) Nothing in this section shall be construed as prohibiting
20 any contract, by definitions or express provisions, from limiting
21 or restricting any or all of the benefits provided under the
22 contract, except in-area and out-of-area emergency services, to
23 those health care services that are delivered by issuer, employed,
24 owned, or contracting providers, and provider facilities, so long
25 as the contract complies with the provisions of Sections 1358.14
26 and 1367 and with Section 1300.67 of *Title 28 of the California*
27 *Code of Regulations*.

28 (c) Nothing in this section shall be construed as prohibiting
29 any contract that limits or restricts any or all of the benefits
30 provided under the contract in the manner contemplated in
31 subdivision (b) from limiting its obligation to deliver services,
32 and disclaiming any liability from any delay or failure to provide
33 those services (1) in the event of a major disaster or epidemic or
34 (2) in the event of circumstances not reasonably within the
35 control of the issuer, such as the partial or total destruction of
36 facilities, war, riot, civil insurrection, disability of a significant
37 part of its health personnel, or similar circumstances so long as
38 the provisions comply with the provisions of subdivision (h) of
39 Section 1367.

1 SEC. 3. Section 1358.6 of the Health and Safety Code is
2 amended to read:

3 1358.6. (a) (1) Except for permitted preexisting condition
4 clauses as described in Sections 1358.7 and 1358.8, a contract
5 shall not be advertised, solicited, or issued for delivery as a
6 Medicare supplement contract if the contract contains definitions,
7 limitations, exclusions, conditions, reductions, or other
8 provisions that are more restrictive or limiting than that term as
9 officially used in Medicare, except as expressly authorized by
10 this article.

11 (2) No issuer may advertise, solicit, or issue for delivery any
12 Medicare supplement contract with hospital or medical coverage
13 if the contract contains any of the prohibited provisions described
14 in subdivision (b).

15 (b) The following provisions shall be deemed to be unfair,
16 unreasonable, and inconsistent with the objectives of this chapter
17 and shall not be contained in any Medicare supplement contract:

18 (1) Any waiver, exclusion, limitation, or reduction based on or
19 relating to a preexisting disease or physical condition, unless that
20 waiver, exclusion, limitation, or reduction (A) applies only to
21 coverage for specified services rendered not more than six
22 months from the effective date of coverage, (B) is based on or
23 relates only to a preexisting disease or physical condition defined
24 no more restrictively than a condition for which medical advice
25 was given or treatment was recommended by or received from a
26 physician within six months before the effective date of
27 coverage, (C) does not apply to any coverage under any group
28 contract, and (D) is approved in advance by the director. Any
29 limitations with respect to a preexisting condition shall appear as
30 a separate paragraph of the contract and be labeled "Preexisting
31 Condition Limitations."

32 (2) Except with respect to a group contract subject to, and in
33 compliance with, Section 1399.62, any provision denying
34 coverage, after termination of the contract, for services provided
35 continuously beginning while the contract was in effect, during
36 the continuous total disability of the subscriber or enrollee,
37 except that the coverage may be limited to a reasonable period of
38 time not less than the duration of the contract benefit period, if
39 any, and may be limited to the maximum benefits provided under
40 the contract.

(c) A Medicare supplement contract in force shall not contain benefits that duplicate benefits provided by Medicare.

(d) (1) Subject to paragraphs (4) and (5) of subdivision (a) of Section 1358.8, a Medicare supplement contract with benefits for outpatient prescription drugs that was issued prior to January 1, 2006, shall be renewed for current enrollees and subscribers, at their option, who do not enroll in Medicare Part D.

(2) A Medicare supplement contract with benefits for outpatient prescription drugs shall not be issued on and after January 1, 2006.

(3) On and after January 1, 2006, a Medicare supplement contract with benefits for outpatient prescription drugs shall not be renewed after the enrollee or subscriber enrolls in Medicare Part D unless both of the following conditions exist:

(A) The contract is modified to eliminate outpatient prescription drug coverage for outpatient prescription drug expenses incurred after the effective date of the individual's coverage under a Medicare Part D plan.

(B) The premium is adjusted to reflect the elimination of outpatient prescription drug coverage at the time of enrollment in Medicare Part D, accounting for any claims paid if applicable.

SEC. 4. Section 1358.8 of the Health and Safety Code is amended to read:

1358.8. The following standards are applicable to all Medicare supplement contracts advertised, solicited, or issued for delivery on or after January 1, 2001. A contract shall not be advertised, solicited, or issued for delivery as a Medicare supplement contract unless it complies with these benefit standards.

(a) The following general standards apply to Medicare supplement contracts and are in addition to all other requirements of this article:

(1) A Medicare supplement contract shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The contract shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a

1 physician within six months before the effective date of
2 coverage.

3 (2) A Medicare supplement contract shall not indemnify
4 against losses resulting from sickness on a different basis than
5 losses resulting from accidents.

6 (3) A Medicare supplement contract shall provide that benefits
7 designed to cover cost-sharing amounts under Medicare will be
8 changed automatically to coincide with any changes in the
9 applicable Medicare deductible amount and copayment
10 percentage factors. Prepaid or periodic charges may be modified
11 to correspond with those changes.

12 (4) A Medicare supplement contract shall not provide for
13 termination of coverage of a spouse solely because of the
14 occurrence of an event specified for termination of coverage of
15 the covered person, other than the nonpayment of the prepaid or
16 periodic charge.

17 (5) Each Medicare supplement contract shall be guaranteed
18 renewable.

19 (A) The issuer shall not cancel or nonrenew the contract solely
20 on the ground of health status of the individual.

21 (B) The issuer shall not cancel or nonrenew the contract for
22 any reason other than nonpayment of the prepaid or periodic
23 charge or misrepresentation of the risk by the applicant that is
24 shown by the plan to be material to the acceptance for coverage.
25 The contestability period for Medicare supplement contracts shall
26 be two years.

27 (C) If a group Medicare supplement contract is terminated by
28 the subscriber and is not replaced as provided under
29 subparagraph (E), the issuer shall offer enrollees an individual
30 Medicare supplement contract that, at the option of the enrollee,
31 either provides for continuation of the benefits contained in the
32 terminated contract or provides for benefits that otherwise meet
33 the requirements of this subsection.

34 (D) If an individual is an enrollee in a group Medicare
35 supplement contract and the individual membership in the group
36 is terminated, the issuer shall either offer the enrollee the
37 conversion opportunity described in subparagraph (C) or, at the
38 option of the subscriber, shall offer the enrollee continuation of
39 coverage under the group contract.

(E) If a group Medicare supplement contract is replaced by another group Medicare supplement contract purchased by the same subscriber, the issuer of the replacement contract shall offer coverage to all persons covered under the old group contract on its date of termination. Coverage under the new contract shall not result in any exclusion for preexisting conditions that would have been covered under the group contract being replaced.

(F) If a Medicare supplement contract eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), the contract as modified as a result of that act shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

(6) Termination of a Medicare supplement contract shall be without prejudice to any continuous loss that commenced while the contract was in force, but the extension of benefits beyond the period during which the contract was in force may be predicated upon the continuous total disability of the covered person, limited to the duration of the contract benefit period, if any, or to payment of the maximum benefits. *Receipt of Medicare Part D benefits shall not be considered in determining a continuous loss.*

(7) (A) (i) A Medicare supplement contract shall provide that benefits and prepaid or periodic charges under the contract shall be suspended at the request of the enrollee for the period, not to exceed 24 months, in which the enrollee has applied for and is determined to be entitled to medical assistance under Title XIX of the federal Social Security Act, but only if the enrollee notifies the issuer of the contract within 90 days after the date the individual becomes entitled to assistance.

~~(B)~~ If suspension occurs and if the enrollee loses entitlement to medical assistance, the contract shall be automatically reinstituted, effective as of the date of termination of entitlement, as of the termination of entitlement if the enrollee provides notice of loss of entitlement within 90 days after the date of loss and pays the prepaid or periodic charge attributable to the period, effective as of the date of termination of entitlement.

~~(C)~~

(ii) A Medicare supplement contract shall provide that benefits and premiums under the contract shall be suspended at the

1 *request of the enrollee or subscriber for any period that may be*
2 *provided by federal regulation if the enrollee or subscriber is*
3 *entitled to benefits under Section 226 (b) of the Social Security*
4 *Act and is covered under a group health plan, as defined in*
5 *Section 1862 (b)(1)(A)(v) of the Social Security Act. If suspension*
6 *occurs and the enrollee or subscriber loses coverage under the*
7 *group health plan, the contract shall be automatically*
8 *reinstated, effective as of the date of loss of coverage if the*
9 *enrollee or subscriber provides notice within 90 days of the date*
10 *of the loss of coverage.*

11 (B) Reinstitution of coverages:

12 (i) Shall not provide for any waiting period with respect to
13 treatment of preexisting conditions.

14 (ii) Shall provide for *resumption of coverage* ~~which~~ that is
15 substantially equivalent to coverage in effect before the date of
16 suspension. *If the suspended Medicare supplement contract*
17 *provided coverage for outpatient prescription drugs, reinstatement*
18 *of the contract for a Medicare Part D enrollee shall not include*
19 *coverage for outpatient prescription drugs but shall otherwise*
20 *provide coverage that is substantially equivalent to the coverage*
21 *in effect before the date of suspension.*

22 (iii) Shall provide for classification of prepaid or periodic
23 charges on terms at least as favorable to the enrollee as the
24 prepaid or periodic charge classification terms that would have
25 applied to the enrollee had the coverage not been suspended.

26 (8) A Medicare supplement contract shall not be limited to
27 coverage for a single disease or affliction.

28 (9) A Medicare supplement contract shall provide an
29 examination period of 30 days after the receipt of the contract by
30 the applicant for purposes of review, during which time the
31 applicant may return the contract as described in subdivision (e)
32 of Section 1358.17.

33 (10) A Medicare supplement contract shall additionally meet
34 any other minimum benefit standards as established by the
35 director.

36 (11) Within 30 days prior to the effective date of any Medicare
37 benefit changes, an issuer shall file with the director, and notify
38 its subscribers and enrollees of, modifications it has made to
39 Medicare supplement contracts.

(A) The notice shall include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement contract.

(B) The notice shall inform each subscriber and enrollee as to when any adjustment in the prepaid or periodic charges will be made due to changes in Medicare benefits.

(C) The notice of benefit modifications and any adjustments to the prepaid or periodic charges shall be in outline form and in clear and simple terms so as to facilitate comprehension. The notice shall not contain or be accompanied by any solicitation.

(12) No modifications to existing Medicare supplement coverage shall be made at the time of, or in connection with, the notice requirements of this article except to the extent necessary to eliminate duplication of Medicare benefits and any modifications necessary under the contract to provide indexed benefit adjustment.

(b) With respect to the standards for basic (core) benefits ~~common to all~~ *for benefit plans A to J, inclusive*, every issuer shall make available a contract including only the following basic “core” package of benefits to each prospective applicant. This “core” package of benefits shall be referred to as standardized Medicare supplement benefit plan “A”. An issuer may make available to prospective applicants any of the other Medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu of it.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day to the 90th day, inclusive, in any Medicare benefit period.

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

(3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of *100 percent of* the Medicare Part A eligible expenses for hospitalization paid at the ~~Medicare diagnostic-related group (DRG) day outlier per diem or other~~ appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer’s

1 payment as payment in full and may not bill the enrollee or
2 subscriber for any balance.

3 (4) Coverage under Medicare Parts A and B for the reasonable
4 cost of the first three pints of blood, or equivalent quantities of
5 packed red blood cells, as defined under federal regulations,
6 unless replaced in accordance with federal regulations.

7 (5) Coverage for the coinsurance amount, or in the case of
8 hospital outpatient services, the copayment amount, of Medicare
9 eligible expenses under Part B regardless of hospital
10 confinement, subject to the Medicare Part B deductible.

11 (c) The following additional benefits shall be included in
12 Medicare supplement benefit plans B to J, inclusive, only as
13 provided by Section 1358.9.

14 (1) With respect to the Medicare Part A deductible, coverage
15 for all of the Medicare Part A inpatient hospital deductible
16 amount per benefit period.

17 (2) With respect to skilled nursing facility care, coverage for
18 the actual billed charges up to the coinsurance amount from the
19 21st day to the 100th day, inclusive, in a Medicare benefit period
20 for posthospital skilled nursing facility care eligible under
21 Medicare Part A.

22 (3) With respect to the Medicare Part B deductible, coverage
23 for all of the Medicare Part B deductible amount per calendar
24 year regardless of hospital confinement.

25 (4) With respect to 80 percent of the Medicare Part B excess
26 charges, coverage for 80 percent of the difference between the
27 actual Medicare Part B charge as billed, not to exceed any charge
28 limitation established by the Medicare program or state law, and
29 the Medicare-approved Part B charge.

30 (5) With respect to 100 percent of the Medicare Part B excess
31 charges, coverage for all of the difference between the actual
32 Medicare Part B charge as billed, not to exceed any charge
33 limitation established by the Medicare program or state law, and
34 the Medicare-approved Part B charge.

35 (6) With respect to the basic outpatient prescription drug
36 benefit, coverage for 50 percent of outpatient prescription drug
37 charges, after a two hundred fifty dollar (\$250) calendar year
38 deductible, to a maximum of one thousand two hundred fifty
39 dollars (\$1,250) in benefits received by the insured per calendar
40 year, to the extent not covered by Medicare. *On and after*

1 *January 1, 2006, no Medicare supplement contract may be sold*
2 *or issued if it includes a prescription drug benefit.*

3 (7) With respect to the extended outpatient prescription drug
4 benefit, coverage for 50 percent of outpatient prescription drug
5 charges, after a two hundred fifty dollar (\$250) calendar year
6 deductible, to a maximum of three thousand dollars (\$3,000) in
7 benefits received by the insured per calendar year, to the extent
8 not covered by Medicare. *On and after January 1, 2006, no*
9 *Medicare supplement contract may be sold or issued if it*
10 *includes a prescription drug benefit.*

11 (8) With respect to medically necessary emergency care in a
12 foreign country, coverage to the extent not covered by Medicare
13 for 80 percent of the billed charges for Medicare-eligible
14 expenses for medically necessary emergency hospital, physician,
15 and medical care received in a foreign country, which care would
16 have been covered by Medicare if provided in the United States
17 and which care began during the first 60 consecutive days of
18 each trip outside the United States, subject to a calendar year
19 deductible of two hundred fifty dollars (\$250), and a lifetime
20 maximum benefit of fifty thousand dollars (\$50,000). For
21 purposes of this benefit, “emergency care” shall mean care
22 needed immediately because of an injury or an illness of sudden
23 and unexpected onset.

24 (9) With respect to the preventive medical care benefit,
25 coverage for the following preventive health services:

26 (A) An annual clinical preventive medical history and physical
27 examination that may include tests and services from
28 subparagraph (B) and patient education to address preventive
29 health care measures.

30 ~~(B) Any one or a combination of the~~ *The following preventive*
31 *screening tests or preventive services that are not covered by*
32 *Medicare, the selection and frequency of which is considered are*
33 *determined to be medically appropriate by the attending*
34 *physician:*

35 (i) ~~Fecal occult blood test or digital rectal examination, or~~
36 ~~both.~~

37 (ii) Mammogram.

38 ~~(iii) Dipstick urinalysis for hematuria, bacteriuria, and~~
39 ~~proteinuria.~~

1 ~~(iv) Pure tone, air only, hearing screening test, administered or~~
2 ~~ordered by a physician.~~

3 ~~(v) Serum cholesterol screening every five years.~~

4 ~~(vi) Thyroid function test.~~

5 ~~(vii) Diabetes screening.~~

6 (C) Influenza vaccine administered at any appropriate time
7 during the year ~~and tetanus and diphtheria booster every 10~~
8 ~~years.~~

9 ~~(D) Any other tests or preventive measures determined~~
10 ~~appropriate by the attending physician.~~

11 Reimbursement shall be for the actual charges up to 100
12 percent of the Medicare-approved amount for each service, as if
13 Medicare were to cover the service as identified in American
14 Medical Association Current Procedural Terminology (AMA
15 CPT) codes, to a maximum of one hundred twenty dollars (\$120)
16 annually under this benefit. This benefit shall not include
17 payment for any procedure covered by Medicare.

18 (10) With respect to the at-home recovery benefit, coverage
19 for services to provide short-term, at-home assistance with
20 activities of daily living for those recovering from an illness,
21 injury, or surgery.

22 (A) For purposes of this benefit, the following definitions shall
23 apply:

24 (i) "Activities of daily living" include, but are not limited to,
25 bathing, dressing, personal hygiene, transferring, eating,
26 ambulating, assistance with drugs that are normally
27 self-administered, and changing bandages or other dressings.

28 (ii) "Care provider" means a duly qualified or licensed home
29 health aide or homemaker, or a personal care aide or nurse
30 provided through a licensed home health care agency or referred
31 by a licensed referral agency or licensed nurses registry.

32 (iii) "Home" shall mean any place used by the insured as a
33 place of residence, provided that the place would qualify as a
34 residence for home health care services covered by Medicare. A
35 hospital or skilled nursing facility shall not be considered the
36 insured's place of residence.

37 (iv) "At-home recovery visit" means the period of a visit
38 required to provide at-home recovery care, without any limit on
39 the duration of the visit, except that each consecutive four hours

1 in a 24-hour period of services provided by a care provider is one
2 visit.

3 (B) With respect to coverage requirements and limitations, the
4 following shall apply:

5 (i) At-home recovery services provided shall be primarily
6 services that assist in activities of daily living.

7 (ii) The covered person's attending physician shall certify that
8 the specific type and frequency of at-home recovery services are
9 necessary because of a condition for which a home care plan of
10 treatment was approved by Medicare.

11 (iii) Coverage is limited to the following:

12 (I) No more than the number and type of at-home recovery
13 visits certified as necessary by the covered person's attending
14 physician. The total number of at-home recovery visits shall not
15 exceed the number of Medicare-approved home health care visits
16 under a Medicare-approved home care plan of treatment.

17 (II) The actual charges for each visit up to a maximum
18 reimbursement of forty dollars (\$40) per visit.

19 (III) One thousand six hundred dollars (\$1,600) per calendar
20 year.

21 (IV) Seven visits in any one week.

22 (V) Care furnished on a visiting basis in the insured's home.

23 (VI) Services provided by a care provider as defined in
24 subparagraph (A).

25 (VII) At-home recovery visits while the covered person is
26 covered under the policy or certificate and not otherwise
27 excluded.

28 (VIII) At-home recovery visits received during the period the
29 covered person is receiving Medicare-approved home care
30 services or no more than eight weeks after the service date of the
31 last Medicare-approved home health care visit.

32 (C) Coverage is excluded for the following:

33 (i) Home care visits paid for by Medicare or other government
34 programs.

35 (ii) Care provided by family members, unpaid volunteers, or
36 providers who are not care providers.

37 ~~(11) With respect to new or innovative benefits, an issuer may,~~
38 ~~with the prior approval of the director, offer contracts with new~~
39 ~~or innovative benefits in addition to the benefits provided in a~~
40 ~~contract that otherwise complies with the applicable standards.~~

~~The new or innovative benefits may include benefits that are appropriate to Medicare supplement contracts, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement contracts.~~

(d) *The standardized Medicare supplement benefit plan “K” shall consist of the following benefits:*

(1) *Coverage of 100 percent of the Medicare Part A hospital coinsurance amount for each day used from the 61st to the 90th day, inclusive, in any Medicare benefit period.*

(2) *Coverage of 100 percent of the Medicare Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st to the 150th day, inclusive, in any Medicare benefit period.*

(3) *Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer’s payment for this benefit as payment in full and shall not bill the enrollee or subscriber for any balance.*

(4) *With respect to the Medicare Part A deductible, coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation described in paragraph (10) is met.*

(5) *With respect to skilled nursing facility care, coverage for 50 percent of the coinsurance amount for each day used from the 21st day to the 100th day, inclusive, in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation described in paragraph (10) is met.*

(6) *With respect to hospice care, coverage for 50 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation described in paragraph (10) is met.*

(7) *Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, as defined under federal*

1 regulations, unless replaced in accordance with federal
2 regulations, until the out-of-pocket limitation described in
3 paragraph (10) is met.

4 (8) Except for coverage provided in paragraph (9), coverage
5 for 50 percent of the cost sharing otherwise applicable under
6 Medicare Part B after the enrollee or subscriber pays the Part B
7 deductible, until the out-of-pocket limitation is met as described
8 in paragraph (10).

9 (9) Coverage of 100 percent of the cost sharing for Medicare
10 Part B preventive services, after the enrollee or subscriber pays
11 the Medicare Part B deductible.

12 (10) Coverage of 100 percent of all cost sharing under
13 Medicare Parts A and B for the balance of the calendar year
14 after the individual has reached the out-of-pocket limitation on
15 annual expenditures under Medicare Parts A and B of four
16 thousand dollars (\$4,000) in 2006, indexed each year by the
17 appropriate inflation adjustment specified by the secretary.

18 (e) The standardized Medicare supplement benefit plan "L"
19 shall consist of the following benefits:

20 (1) The benefits described in paragraphs (1), (2), (3), and (9)
21 of subdivision (d).

22 (2) With respect to the Medicare Part A deductible, coverage
23 for 75 percent of the Medicare Part A inpatient hospital
24 deductible amount per benefit period until the out-of-pocket
25 limitation described in paragraph (8) is met.

26 (3) With respect to skilled nursing facility care, coverage for
27 75 percent of the coinsurance amount for each day used from the
28 21st day to the 100th day, inclusive, in a Medicare benefit period
29 for posthospital skilled nursing facility care eligible under
30 Medicare Part A until the out-of-pocket limitation described in
31 paragraph (8) is met.

32 (4) With respect to hospice care, coverage for 75 percent of
33 cost sharing for all Medicare Part A eligible expenses and
34 respite care until the out-of-pocket limitation described in
35 paragraph (8) is met.

36 (5) Coverage for 75 percent, under Medicare Part A or B, of
37 the reasonable cost of the first three pints of blood or equivalent
38 quantities of packed red blood cells, as defined under federal
39 regulations, unless replaced in accordance with federal

1 *regulations, until the out-of-pocket limitation described in*
2 *paragraph (8) is met.*

3 *(6) Except for coverage provided in paragraph (7), coverage*
4 *for 75 percent of the cost sharing otherwise applicable under*
5 *Medicare Part B after the enrollee or subscriber pays the Part B*
6 *deductible until the out-of-pocket limitation described in*
7 *paragraph (8) is met.*

8 *(7) Coverage for 100 percent of the cost sharing for Medicare*
9 *Part B preventive services after the enrollee or subscriber pays*
10 *the Part B deductible.*

11 *(8) Coverage of 100 percent of the cost sharing for Medicare*
12 *Parts A and B for the balance of the calendar year after the*
13 *individual has reached the out-of-pocket limitation on annual*
14 *expenditures under Medicare Parts A and B of two thousand*
15 *dollars (\$2,000) in 2006, indexed each year by the appropriate*
16 *inflation adjustment specified by the secretary.*

17 *(f) A contract shall not contain any provision delaying the*
18 *effective date of coverage beyond the first day of the month*
19 *following the date of receipt by the issuer of the applicant's*
20 *properly completed application, except that the effective date of*
21 *coverage may be delayed until the 65th birthday of an applicant*
22 *who is to become eligible for Medicare by reason of age if the*
23 *application is received any time during the three months*
24 *immediately preceding the applicant's 65th birthday.*

25 SEC. 5. Section 1358.9 of the Health and Safety Code is
26 amended to read:

27 1358.9. (a) An issuer shall make available to each
28 prospective enrollee a contract form containing only the basic
29 (core) benefits, as defined in subdivision (b) of Section 1358.8.

30 (b) No groups, packages, or combinations of Medicare
31 supplement benefits other than those listed in this section shall be
32 offered for sale in this state, except as may be permitted by
33 ~~paragraph (11) of subdivision (c) of Section 1358.8~~ *subdivision*
34 *(f) and by Section 1358.10.*

35 (c) Benefit plans shall be uniform in structure, language,
36 designation and format to the standard benefit plans A to J,
37 inclusive, listed in subdivision (e), and shall conform to the
38 definitions in Section 1358.4. Each benefit shall be structured in
39 accordance with the format provided in subdivisions (b) ~~and~~, (c),
40 *(d), and (e) of Section 1358.8 and list the benefits in the order*

1 listed in subdivision (e). For purposes of this section, “structure,
2 language, and format” means style, arrangement, and overall
3 content of a benefit.

4 (d) An issuer may use, in addition to the benefit plan
5 designations required in subdivision (c), other designations to the
6 extent permitted by law.

7 (e) With respect to the makeup of benefit plans, the following
8 shall apply:

9 (1) Standardized Medicare supplement benefit plan A shall be
10 limited to the basic (core) benefit common to all benefit plans, as
11 defined in subdivision (b) of Section 1358.8.

12 (2) Standardized Medicare supplement benefit plan B shall
13 include only the following: the core benefit, plus the Medicare
14 Part A deductible as defined in paragraph (1) of subdivision (c)
15 of Section 1358.8.

16 (3) Standardized Medicare supplement benefit plan C shall
17 include only the following: the core benefit, plus the Medicare
18 Part A deductible, skilled nursing facility care, Medicare Part B
19 deductible, and medically necessary emergency care in a foreign
20 country as defined in paragraphs (1), (2), (3), and (8) of
21 subdivision (c) of Section 1358.8, respectively.

22 (4) Standardized Medicare supplement benefit plan D shall
23 include only the following: the core benefit, plus the Medicare
24 Part A deductible, skilled nursing facility care, medically
25 necessary emergency care in a foreign country, and the at-home
26 recovery benefit as defined in paragraphs (1), (2), (8), and (10) of
27 subdivision (c) of Section 1358.8, respectively.

28 (5) Standardized Medicare supplement benefit plan E shall
29 include only the following: the core benefit, plus the Medicare
30 Part A deductible, skilled nursing facility care, medically
31 necessary emergency care in a foreign country, and preventive
32 medical care as defined in paragraphs (1), (2), (8), and (9) of
33 subdivision (c) of Section 1358.8, respectively.

34 (6) Standardized Medicare supplement benefit plan F shall
35 include only the following: the core benefit, plus the Medicare
36 Part A deductible, the skilled nursing facility care, the Medicare
37 Part B deductible, 100 percent of the Medicare Part B excess
38 charges, and medically necessary emergency care in a foreign
39 country as defined in paragraphs (1), (2), (3), (5), and (8) of
40 subdivision (c) of Section 1358.8, respectively.

1 (7) Standardized Medicare supplement benefit high deductible
2 plan F shall include only the following: 100 percent of covered
3 expenses following the payment of the annual high deductible
4 plan F deductible. The covered expenses include the core benefit,
5 plus the Medicare Part A deductible, skilled nursing facility care,
6 the Medicare Part B deductible, 100 percent of the Medicare Part
7 B excess charges, and medically necessary emergency care in a
8 foreign country as defined in paragraphs (1), (2), (3), (5), and (8)
9 of subdivision (c) of Section 1358.8, respectively. The annual
10 high deductible plan F deductible shall consist of out-of-pocket
11 expenses, other than premiums, for services covered by the
12 Medicare supplement plan F policy, and shall be in addition to
13 any other specific benefit deductibles. The annual high
14 deductible Plan F deductible shall be one thousand five hundred
15 dollars (\$1,500) for 1998 and 1999, and shall be based on the
16 calendar year, as adjusted annually thereafter by the secretary to
17 reflect the change in the Consumer Price Index for all urban
18 consumers for the 12-month period ending with August of the
19 preceding year, and rounded to the nearest multiple of ten dollars
20 (\$10).

21 (8) Standardized Medicare supplement benefit plan G shall
22 include only the following: the core benefit, plus the Medicare
23 Part A deductible, skilled nursing facility care, 80 percent of the
24 Medicare Part B excess charges, medically necessary emergency
25 care in a foreign country, and the at-home recovery benefit as
26 defined in paragraphs (1), (2), (4), (8), and (10) of Section
27 1358.8, respectively.

28 (9) Standardized Medicare supplement benefit plan H shall
29 consist of only the following: the core benefit, plus the Medicare
30 Part A deductible, skilled nursing facility care, basic outpatient
31 prescription drug benefit, and medically necessary emergency
32 care in a foreign country as defined in paragraphs (1), (2), (6),
33 and (8) of Section 1358.8, respectively. *The outpatient*
34 *prescription drug benefit shall not be included in a Medicare*
35 *supplement contract sold on or after January 1, 2006.*

36 (10) Standardized Medicare supplement benefit plan I shall
37 consist of only the following: the core benefit, plus the Medicare
38 Part A deductible, skilled nursing facility care, 100 percent of the
39 Medicare Part B excess charges, basic outpatient prescription
40 drug benefit, medically necessary emergency care in a foreign

country, and at-home recovery benefit as defined in paragraphs (1), (2), (5), (6), (8), and (10) of subdivision (c) of Section 1358.8, respectively. *The outpatient prescription drug benefit shall not be included in a Medicare supplement contract sold on or after January 1, 2006.*

(11) Standardized Medicare supplement benefit plan J shall consist of only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined in paragraphs (1), (2), (3), (5), (7), (8), (9), and (10) of subdivision (c) of Section 1358.8, respectively. *The outpatient prescription drug benefit shall not be included in a Medicare supplement contract sold on or after January 1, 2006.*

(12) Standardized Medicare supplement benefit high deductible plan J shall consist of only the following: 100 percent of covered expenses following the payment of the annual high deductible plan J deductible. The covered expenses include the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit, and at-home recovery benefit as defined in paragraphs (1), (2), (3), (5), (7), (8), (9), and (10) of subdivision (c) of Section 1358.8, respectively. The annual high deductible plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan J policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be one thousand five hundred dollars (\$1,500) for 1998 and 1999, and shall be based on a calendar year, as adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10). *The outpatient prescription drug benefit shall not be included in a Medicare supplement contract sold on or after January 1, 2006.*

1 (13) *Standardized Medicare supplement benefit plan K shall*
2 *consist of only those benefits described in subdivision (d) of*
3 *Section 1358.8.*

4 (14) *Standardized Medicare supplement benefit plan L shall*
5 *consist of only those benefits described in subdivision (e) of*
6 *Section 1358.8.*

7 (f) *An issuer may, with the prior approval of the director, offer*
8 *contracts with new or innovative benefits in addition to the*
9 *benefits provided in a contract that otherwise complies with the*
10 *applicable standards. The new or innovative benefits may include*
11 *benefits that are appropriate to Medicare supplement contracts,*
12 *that are not otherwise available and that are cost-effective and*
13 *offered in a manner that is consistent with the goal of*
14 *simplification of Medicare supplement contracts. On and after*
15 *January 1, 2006, the innovative benefit shall not include an*
16 *outpatient prescription drug benefit.*

17 SEC. 6. Section 1358.10 of the Health and Safety Code is
18 amended to read:

19 1358.10. (a) (1) This section shall apply to Medicare Select
20 contracts, as defined in this section.

21 (2) A contract shall not be advertised as a Medicare Select
22 contract unless it meets the requirements of this section.

23 (b) For the purposes of this section:

24 (1) “Complaint” means any dissatisfaction expressed by an
25 individual concerning a Medicare Select issuer or its network
26 providers.

27 (2) “Grievance” means dissatisfaction expressed in writing by
28 an individual covered by a Medicare Select contract with the
29 administration, claims practices, or provision of services
30 concerning a Medicare Select issuer or its network providers.

31 (3) “Medicare Select issuer” means an issuer offering, or
32 seeking to offer, a Medicare Select contract.

33 (4) “Medicare Select contract” means a Medicare supplement
34 contract that contains restricted network provisions.

35 (5) “Network provider” means a provider of health care, or a
36 group of providers of health care, which has entered into a
37 written agreement with the issuer to provide benefits covered
38 under a Medicare Select contract. “Provider network” means a
39 grouping of network providers.

1 (6) “Restricted network provision” means any provision which
2 conditions the payment of benefits, in whole or in part, on the use
3 of network providers.

4 (7) “Service area” means the geographic area approved by the
5 director within which an issuer is authorized to offer a Medicare
6 Select contract.

7 (c) The director may authorize an issuer to offer a Medicare
8 Select contract pursuant to Section 4358 of the federal Omnibus
9 Budget Reconciliation Act (OBRA) of 1990 if the director finds
10 that the issuer’s Medicare Select contracts are in compliance with
11 this chapter and if the director finds that the issuer has satisfied
12 all of the requirements of this section.

13 (d) A Medicare Select issuer shall not issue a Medicare Select
14 contract in this state until its plan of operation has been approved
15 by the director.

16 (e) A Medicare Select issuer shall file a proposed plan of
17 operation with the director in a format prescribed by the director.
18 The plan of operation shall contain at least the following
19 information:

20 (1) Evidence that all covered services that are subject to
21 restricted network provisions are available and accessible
22 through network providers, including a demonstration of all of
23 the following:

24 (A) That services can be provided by network providers with
25 reasonable promptness with respect to geographic location, hours
26 of operation, and afterhour care. The hours of operation and
27 availability of afterhour care shall reflect usual practice in the
28 local area. Geographic availability shall reflect the usual travel
29 times within the community.

30 (B) That the number of network providers in the service area
31 is sufficient, with respect to current and expected enrollees, as to
32 either of the following:

33 (i) To deliver adequately all services that are subject to a
34 restricted network provision.

35 (ii) To make appropriate referrals.

36 (C) There are written agreements with network providers
37 describing specific responsibilities.

38 (D) Emergency care is available 24 hours per day and seven
39 days per week.

1 (E) In the case of covered services that are subject to a
2 restricted network provision and are provided on a prepaid basis,
3 that there are written agreements with network providers
4 prohibiting the providers from billing or otherwise seeking
5 reimbursement from or recourse against any individual covered
6 under a Medicare Select contract.

7 This subparagraph shall not apply to supplemental charges or
8 coinsurance amounts as stated in the Medicare Select contract.

9 (2) A statement or map providing a clear description of the
10 service area.

11 (3) A description of the grievance procedure to be utilized.

12 (4) A description of the quality assurance program, including
13 all of the following:

14 (A) The formal organizational structure.

15 (B) The written criteria for selection, retention, and removal of
16 network providers.

17 (C) The procedures for evaluating quality of care provided by
18 network providers, and the process to initiate corrective action
19 when warranted.

20 (5) A list and description, by specialty, of the network
21 providers.

22 (6) Copies of the written information proposed to be used by
23 the issuer to comply with subdivision (i).

24 (7) Any other information requested by the director.

25 (f) (1) A Medicare Select issuer shall file any proposed
26 changes to the plan of operation, except for changes to the list of
27 network providers, with the director prior to implementing the
28 changes. Changes shall be considered approved by the director
29 after 30 days unless specifically disapproved.

30 (2) An updated list of network providers shall be filed with the
31 director at least quarterly.

32 (g) A Medicare Select contract shall not restrict payment for
33 covered services provided by nonnetwork providers if:

34 (1) The services are for symptoms requiring emergency care
35 or are immediately required for an unforeseen illness, injury, or
36 condition.

37 (2) It is not reasonable to obtain services through a network
38 provider.

1 (h) A Medicare Select contract shall provide payment for full
2 coverage under the contract for covered services that are not
3 available through network providers.

4 (i) A Medicare Select issuer shall make full and fair disclosure
5 in writing of the provisions, restrictions, and limitations of the
6 Medicare Select contract to each applicant. This disclosure shall
7 include at least the following:

8 (1) An outline of coverage sufficient to permit the applicant to
9 compare the coverage and charges of the Medicare Select
10 contract with both of the following:

11 (A) Other Medicare supplement contracts offered by the
12 issuer.

13 (B) Other Medicare Select contracts.

14 (2) A description, including address, telephone number, and
15 hours of operation, of the network providers, including primary
16 care physicians, specialty physicians, hospitals, and other
17 providers.

18 (3) A description of the restricted network provisions,
19 including payments for coinsurance and deductibles when
20 providers other than network providers are utilized. *The*
21 *description shall inform the applicant that expenses incurred*
22 *when using out-of-network providers are excluded from the*
23 *out-of-pocket annual limit in benefit plans K and L, unless the*
24 *contract provides otherwise.*

25 (4) A description of coverage for emergency and urgently
26 needed care and other out-of-service area coverage.

27 (5) A description of limitations on referrals to restricted
28 network providers and to other providers.

29 (6) A description of the enrollee's rights to purchase any other
30 Medicare supplement contract otherwise offered by the issuer.

31 (7) A description of the Medicare Select issuer's quality
32 assurance program and grievance procedure.

33 (j) Prior to the sale of a Medicare Select contract, a Medicare
34 Select issuer shall obtain from the applicant a signed and dated
35 form stating that the applicant has received the information
36 provided pursuant to subdivision (i) and that the applicant
37 understands the restrictions of the Medicare Select contract.

38 (k) A Medicare Select issuer shall have and use procedures for
39 hearing complaints and resolving written grievances from the

1 enrollees. The procedures shall be aimed at mutual agreement for
2 settlement and may include arbitration procedures.

3 (1) The grievance procedure shall be described in the contract
4 and in the outline of coverage.

5 (2) At the time the contract is issued, the issuer shall provide
6 detailed information to the enrollee describing how a grievance
7 may be registered with the issuer.

8 (3) Grievances shall be considered in a timely manner and
9 shall be transmitted to appropriate decisionmakers who have
10 authority to fully investigate the issue and take corrective action.

11 (4) If a grievance is found to be valid, corrective action shall
12 be taken promptly.

13 (5) All concerned parties shall be notified about the results of
14 a grievance.

15 (6) The issuer shall report no later than each March 31st to the
16 director regarding its grievance procedure. The report shall be in
17 a format prescribed by the director and shall contain the number
18 of grievances filed in the past year and a summary of the subject,
19 nature, and resolution of those grievances.

20 (l) At the time of initial purchase, a Medicare Select issuer
21 shall make available to each applicant for a Medicare Select
22 contract the opportunity to purchase any Medicare supplement
23 contract otherwise offered by the issuer.

24 (m) (1) At the request of an enrollee under a Medicare Select
25 contract, a Medicare Select issuer shall make available to the
26 enrollee the opportunity to purchase a Medicare supplement
27 contract offered by the issuer that has comparable or lesser
28 benefits and that does not contain a restricted network provision,
29 if a Medicare supplement contract of that nature is offered by the
30 issuer. The issuer shall make the contracts available without
31 regard to the health status of the enrollee and without requiring
32 evidence of insurability after the Medicare Select contract has
33 been in force for six months.

34 (2) For the purposes of this subdivision, a Medicare
35 supplement contract will be considered to have comparable or
36 lesser benefits unless it contains one or more significant benefits
37 not included in the Medicare Select contract being replaced. For
38 the purposes of this paragraph, a significant benefit means
39 coverage for the Medicare Part A deductible, ~~coverage for~~

1 ~~prescription drugs~~, coverage for at-home recovery services, or
2 coverage for Medicare Part B excess charges.

3 (n) Medicare Select contracts shall provide for continuation of
4 coverage in the event the secretary determines that Medicare
5 Select contracts issued pursuant to this section should be
6 discontinued due to either the failure of the Medicare Select
7 program to be reauthorized under law or its substantial
8 amendment.

9 (1) Each Medicare Select issuer shall make available to each
10 enrollee covered by a Medicare Select contract the opportunity to
11 purchase any Medicare supplement contract offered by the issuer
12 that has comparable or lesser benefits and that does not contain a
13 restricted provider network provision, if a Medicare supplement
14 contract of that nature is offered by the issuer. The issuer shall
15 make the contracts available without regard to the health status of
16 the enrollee and without requiring evidence of insurability after
17 the Medicare Select contract has been in force for six months.

18 (2) For the purposes of this subdivision, a Medicare
19 supplement contract will be considered to have comparable or
20 lesser benefits unless it contains one or more significant benefits
21 not included in the Medicare Select contract being replaced. For
22 the purposes of this paragraph, a significant benefit means
23 coverage for the Medicare Part A deductible, ~~coverage for~~
24 ~~prescription drugs~~, coverage for at-home recovery services, or
25 coverage for Medicare Part B excess charges.

26 (o) An issuer offering Medicare Select contracts shall comply
27 with reasonable requests for data made by state or federal
28 agencies, including the United States Department of Health and
29 Human Services, for the purpose of evaluating the Medicare
30 Select program. An issuer shall not issue a Medicare Select
31 contract in this state until the contract has been approved by the
32 director.

33 SEC. 7. Section 1358.11 of the Health and Safety Code is
34 amended to read:

35 1358.11. (a) An issuer shall not deny or condition the
36 offering or effectiveness of any Medicare supplement contract
37 available for sale in this state, nor discriminate in the pricing of a
38 contract because of the health status, claims experience, receipt
39 of health care, or medical condition of an applicant in the case of
40 an application for a contract that is submitted prior to or during

1 the six-month period beginning with the first day of the first
2 month in which an individual is ~~both 65 years of age or older and~~
3 ~~is enrolled for benefits under Medicare Part B. Each Medicare~~
4 ~~supplement contract currently available from an issuer shall be~~
5 ~~made available to all applicants who qualify under this~~
6 ~~subdivision and are 65 years of age or older. Medicare~~
7 ~~supplement contracts A, B, C, F, and at least one~~
8 ~~letter-designated plan (H, I, or J, at the discretion of the issuer)~~
9 ~~that includes coverage for prescription medications, if currently~~
10 ~~available from an issuer, shall be made available to any applicant~~
11 ~~who qualifies under this subdivision who is 64 years of age or~~
12 ~~younger and who does not have End-Stage Renal Disease. This~~
13 ~~section and Section 1358.12 do not prohibit an issuer in~~
14 ~~determining subscriber rates from treating applicants who are~~
15 ~~under 65 years of age and are eligible for Medicare Part B as a~~
16 ~~separate risk classification.~~

17 (b) (1) If an applicant qualifies under subdivision (a) and
18 submits an application during the time period referenced in
19 subdivision (a) and, as of the date of application, has had a
20 continuous period of creditable coverage of at least six months,
21 the issuer shall not exclude benefits based on a preexisting
22 condition.

23 (2) If the applicant qualifies under subdivision (a) and submits
24 an application during the time period referenced in subdivision
25 (a) and, as of the date of application, has had a continuous period
26 of creditable coverage that is less than six months, the issuer
27 shall reduce the period of any preexisting condition exclusion by
28 the aggregate of the period of creditable coverage applicable to
29 the applicant as of the enrollment date. The manner of the
30 reduction under this subdivision shall be as specified by the
31 director.

32 (c) Except as provided in subdivision (b) and Section 1358.23,
33 subdivision (a) shall not be construed as preventing the exclusion
34 of benefits under a contract, during the first six months, based on
35 a preexisting condition for which the enrollee received treatment
36 or was otherwise diagnosed during the six months before the
37 coverage became effective.

38 (d) ~~An individual enrolled in Medicare by reason of disability~~
39 ~~shall be entitled to open enrollment described in this section for~~
40 ~~six months after he or she enrolled in Medicare Part B, or if~~

1 notified retroactively of his or her eligibility for Medicare, for six
2 months following notice of eligibility. Sales during the open
3 enrollment period shall not be discouraged by any means,
4 including the altering of the commission structure.

5 ~~There shall be a one-time open enrollment period of 90 days~~
6 ~~commencing on January 1, 2004, for all individuals eligible for~~
7 ~~Medicare by reason of disability who do not have End-Stage~~
8 ~~Renal Disease and who did not use the prior one-time open~~
9 ~~enrollment that commenced on January 1, 2001. Notice of this~~
10 ~~one-time open enrollment right shall be publicized on the Web~~
11 ~~sites of the Department of Managed Health Care, the Department~~
12 ~~of Insurance, and the Department of Aging, through those~~
13 ~~departments' written materials directed to Medicare~~
14 ~~beneficiaries, and by the Health Insurance Counseling Advisory~~
15 ~~Program (HICAP), beginning January 1, 2003.~~

16 (e) (1) An individual enrolled in Medicare Part B is entitled to
17 open enrollment described in this section for six months
18 following:

19 ~~(1)~~

20 (A) Receipt of a notice of termination or, if no notice is
21 received, the effective date of termination from any
22 employer-sponsored health plan including an
23 employer-sponsored retiree health plan.

24 ~~(2)~~

25 (B) Receipt of a notice of loss of eligibility due to the divorce
26 or death of a spouse or, if no notice is received, the effective date
27 of loss of eligibility due to the divorce or death of a spouse, from
28 any employer-sponsored health plan including an
29 employer-sponsored retiree health plan.

30 ~~(3)~~

31 (C) Termination of health care services for a military retiree or
32 the retiree's Medicare eligible spouse or dependent as a result of
33 a military base closure or loss of access to health care services
34 because the base no longer offers services or because the
35 individual relocates.

36 (2) For purposes of this subdivision, "employer-sponsored
37 retiree health plan" includes any coverage for medical expenses
38 that is directly or indirectly sponsored or established by an
39 employer for employees or retirees, their spouses, dependents, or
40 other included covered persons.

(f) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section if the individual was covered under a policy, certificate, or contract providing Medicare supplement coverage but that coverage terminated because the individual established residence at a location not served by the issuer.

(g) (1) An individual whose coverage was terminated by a Medicare-managed-care *Advantage* plan shall be entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation, for any and all Medicare supplement coverage available on a guaranteed basis under state and federal law or regulations for persons terminated by their Medicare ~~managed-care~~ *Advantage* plan.

(2) Health plans that terminate Medicare enrollees shall notify those enrollees in the termination notice of the additional open enrollment period authorized by this subdivision. Health plan notices shall inform enrollees of the opportunity to secure advice and assistance from the HICAP in their area, along with the toll-free telephone number for HICAP.

(h) An individual shall be entitled to an annual open enrollment period lasting 30 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement coverage, ~~with the exception of a Medicare Select contract~~, that offers benefits equal to or lesser than those provided by the previous coverage. During this open enrollment period, no issuer that falls under this provision shall deny or condition the issuance or effectiveness of Medicare supplement coverage, nor discriminate in the pricing of coverage, because of health status, claims experience, receipt of health care, or medical condition of the individual if, at the time of the open enrollment period, the individual is covered under another Medicare supplement policy, certificate, or contract. An issuer that offers Medicare supplement contracts shall notify an enrollee of his or her rights under this subdivision at least 30 and no more than 60 days before the beginning of the open enrollment period.

(i) *An individual enrolled in Medicare Part B is entitled to open enrollment described in this section upon being notified that he or she is no longer eligible for benefits under the Medi-Cal program.*

1 SEC. 8. Section 1358.12 of the Health and Safety Code is
2 repealed.

3 ~~1358.12. (a) (1) With respect to the guaranteed issue of a~~
4 ~~Medicare supplement contract, eligible persons are those~~
5 ~~individuals described in subdivision (b) who apply to enroll~~
6 ~~under the contract not later than 63 days after the date of the~~
7 ~~termination of enrollment described in subdivision (b), and who~~
8 ~~submit evidence of the date of termination or disenrollment with~~
9 ~~the application for a Medicare supplement contract.~~

10 ~~(2) With respect to eligible persons, an issuer shall not deny or~~
11 ~~condition the issuance or effectiveness of a Medicare supplement~~
12 ~~contract described in subdivision (c) that is offered and is~~
13 ~~available for issuance to new enrollees by the issuer, shall not~~
14 ~~discriminate in the pricing of the Medicare supplement contract~~
15 ~~because of health status, claims experience, receipt of health~~
16 ~~care, or medical condition, and shall not impose an exclusion of~~
17 ~~benefits based on a preexisting condition under the Medicare~~
18 ~~supplement contract.~~

19 ~~(3) Issuers shall issue coverage with an effective date not later~~
20 ~~than the date of termination of previous benefits or the date~~
21 ~~requested on the application, but in no event earlier than the date~~
22 ~~of application for coverage. Issuers shall issue coverage so that~~
23 ~~there is no duplication or overlap of coverage.~~

24 ~~(b) An eligible person is an individual described in any of the~~
25 ~~following paragraphs:~~

26 ~~(1) The individual is enrolled under an employee welfare~~
27 ~~benefit plan that provides health benefits that supplement the~~
28 ~~benefits under Medicare, and the plan terminates, the individual~~
29 ~~loses his or her eligibility to continue benefits due to the divorce~~
30 ~~or death of a spouse, or the plan ceases to provide some, all, or~~
31 ~~substantially all of those supplemental health benefits to the~~
32 ~~individual and the employer no longer provides the individual~~
33 ~~with insurance that covers all of the payment for the Part B~~
34 ~~20-percent coinsurance.~~

35 ~~(2) The individual is enrolled with a Medicare+Choice~~
36 ~~organization under a Medicare+Choice plan under Medicare Part~~
37 ~~C, and any of the following apply:~~

38 ~~(A) The organization's or plan's certification, under this part,~~
39 ~~has been terminated or the organization has terminated or~~

1 otherwise discontinued providing the plan in the area in which
2 the individual resides.

3 (B) The individual is no longer eligible to elect the plan
4 because of a change in the individual's place of residence or
5 other change in circumstances specified by the secretary, but not
6 including termination of the individual's enrollment on the basis
7 described in Section 1851(g)(3)(B) of the federal Social Security
8 Act, where the individual has not paid premiums on a timely
9 basis or has engaged in disruptive behavior as specified in
10 standards under Section 1856 of that act, or the plan is terminated
11 for all individuals within a residence area.

12 (C) The individual demonstrates, in accordance with
13 guidelines established by the director, either of the following:

14 (i) The organization offering the plan substantially violated a
15 material provision of the organization's contract under this article
16 in relation to the individual, including the failure to provide an
17 enrollee on a timely basis medically necessary care for which
18 benefits are available under the plan or the failure to provide the
19 covered care in accordance with applicable quality standards.

20 (ii) The organization, or agent or other entity acting on the
21 organization's behalf, materially misrepresented the plan's
22 provisions in marketing the plan to the individual.

23 (D) The Medicare+Choice plan in which the individual is
24 enrolled reduces any of the benefits under the plan or increases
25 the cost-sharing amount or discontinues for other than good
26 cause relating to the quality of care under the plan, a provider
27 who is currently furnishing services to the individual. However,
28 with respect to eligibility under this subparagraph, an individual
29 shall be eligible only for a Medicare supplement contract issued
30 by the same health care service plan through which the individual
31 is enrolled at the time the reduction, increase, or discontinuance
32 described above occurs. The change to another plan contract may
33 occur no more frequently than every two years.

34 (E) The individual meets other exceptional conditions as the
35 director may provide.

36 (3) The individual meets both of the following conditions:

37 (A) The individual is enrolled with any of the following:

38 (i) An eligible organization under a contract under Section
39 1876 of the federal Social Security Act (Medicare risk or cost):

1 ~~(ii) A similar organization operating under demonstration~~
2 ~~project authority, effective for periods before April 1, 1999.~~

3 ~~(iii) An organization under an agreement under Section~~
4 ~~1833(a)(1)(A) of the federal Social Security Act (health care~~
5 ~~prepayment plan).~~

6 ~~(iv) An organization under a Medicare Select policy.~~

7 ~~(B) The individual's enrollment ceases under the same~~
8 ~~circumstances that would permit discontinuance of an~~
9 ~~individual's election of coverage under the first sentence of~~
10 ~~Section 1851(c)(4) of the federal Social Security Act as~~
11 ~~delineated in paragraph (2) of subdivision (b).~~

12 ~~(4) The individual is enrolled under a Medicare supplement~~
13 ~~contract and the enrollment ceases because of the following: the~~
14 ~~insolvency of the issuer or bankruptcy of the nonissuer~~
15 ~~organization; the involuntary termination of coverage or~~
16 ~~enrollment under the contract; the issuer of the contract~~
17 ~~substantially violated a material provision of the contract; or the~~
18 ~~issuer, or an agent or other entity acting on the issuer's behalf,~~
19 ~~materially misrepresented the contract's provisions in marketing~~
20 ~~the contract to the individual.~~

21 ~~(5) The individual meets both of the following conditions:~~

22 ~~(A) The individual was enrolled under a Medicare supplement~~
23 ~~contract and terminates enrollment and subsequently enrolls, for~~
24 ~~the first time, with any Medicare+Choice organization under a~~
25 ~~Medicare+Choice plan under Medicare Part C, any eligible~~
26 ~~organization under a contract under Section 1876 of the federal~~
27 ~~Social Security Act (Medicare risk or cost), any similar~~
28 ~~organization operating under demonstration project authority, an~~
29 ~~organization under an agreement under Section 1833(a)(1)(A) of~~
30 ~~the federal Social Security Act (health care prepayment plan), or~~
31 ~~a Medicare Select contract.~~

32 ~~(B) The subsequent enrollment under subparagraph (A) is~~
33 ~~terminated by the enrollee during any period within the first 12~~
34 ~~months of the subsequent enrollment (during which the enrollee~~
35 ~~is permitted to terminate the subsequent enrollment under~~
36 ~~Section 1851(c) of the federal Social Security Act).~~

37 ~~(6) The individual, upon first becoming eligible for benefits~~
38 ~~under Medicare Part A who postpones enrollment in Medicare~~
39 ~~Part A or Part B while eligible for employer-sponsored coverage,~~
40 ~~enrolls in a Medicare+Choice plan under Medicare Part C, and~~

1 disenrolls from the plan by not later than 12 months after the
2 effective date of enrollment.

3 ~~(c) (1) Under paragraphs (1), (2), (3), and (4) of subdivision~~
4 ~~(b), eligible persons are entitled to a Medicare supplement~~
5 ~~contract that has a benefit package classified as plan A, B, C, F,~~
6 ~~and at least one letter-designated plan (H, I, or J, at the discretion~~
7 ~~of the issuer) that includes coverage for prescription medications;~~
8 ~~if currently available from an issuer.~~

9 ~~(2) Under paragraph (5) of subdivision (b), eligible persons are~~
10 ~~entitled to the same Medicare supplement contract in which they~~
11 ~~were most recently previously enrolled, if available from the~~
12 ~~same issuer, or, if not so available, a contract described in~~
13 ~~paragraph (1) of subdivision (c).~~

14 ~~(3) Under paragraph (6) of subdivision (b), eligible persons are~~
15 ~~entitled to any Medicare supplement contract offered by any~~
16 ~~issuer.~~

17 ~~(d) (1) At the time of an event described in subdivision (b)~~
18 ~~because of which an individual loses coverage or benefits due to~~
19 ~~the termination of a contract or agreement, policy, or plan, the~~
20 ~~organization that terminates the contract or agreement, the issuer~~
21 ~~terminating the contract, or the administrator of the plan being~~
22 ~~terminated, respectively, shall notify the individual of his or her~~
23 ~~rights under this section, and of the obligations of issuers of~~
24 ~~Medicare supplement contracts under subdivision (a). That notice~~
25 ~~shall be communicated contemporaneously with the notification~~
26 ~~of termination.~~

27 ~~(2) At the time of an event described in subdivision (b)~~
28 ~~because of which an individual ceases enrollment under a~~
29 ~~contract or agreement, policy, or plan, the organization that~~
30 ~~offers the contract or agreement, regardless of the basis for the~~
31 ~~cessation of enrollment, the issuer offering the contract, or the~~
32 ~~administrator of the plan, respectively, shall notify the individual~~
33 ~~of his or her rights under this section, and of the obligations of~~
34 ~~issuers of Medicare supplement contracts under subdivision (a).~~
35 ~~That notice shall be communicated within ten working days of~~
36 ~~the issuer receiving notification of disenrollment.~~

37 ~~(e) Issuers shall refund any unearned monthly premium paid in~~
38 ~~advance and terminate coverage upon the request of any insured~~
39 ~~person.~~

SEC. 9. Section 1358.12 is added to the Health and Safety Code, to read:

1358.12. (a) (1) With respect to the guaranteed issue of a Medicare supplement contract, eligible persons are those individuals described in subdivision (b) who seek to enroll under the contract during the period specified in subdivision (c), and who submit evidence of the date of termination or disenrollment or enrollment in Medicare Part D with the application for a Medicare supplement contract.

(2) With respect to eligible persons, an issuer shall not take any of the following actions:

(A) Deny or condition the issuance or effectiveness of a Medicare supplement contract described in subdivision (e) that is offered and is available for issuance to new enrollees by the issuer.

(B) Discriminate in the pricing of that Medicare supplement contract because of health status, claims experience, receipt of health care, or medical condition.

(C) Impose an exclusion of benefits based on a preexisting condition under that Medicare supplement contract.

(b) An eligible person is an individual described in any of the following paragraphs:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan either terminates or ceases to provide all of those supplemental health benefits to the individual.

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, and any of the following circumstances apply:

(A) The certification of the organization or plan has been terminated.

(B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.

(C) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary. Those changes in circumstances shall not include termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act where the

1 individual has not paid premiums on a timely basis or has
2 engaged in disruptive behavior as specified in standards under
3 Section 1856, or the plan is terminated for all individuals within
4 a residence area.

5 (D) The Medicare Advantage plan in which the individual is
6 enrolled reduces any of its benefits or increases the amount of
7 cost sharing or discontinues for other than good cause relating to
8 quality of care, its relationship or contract under the plan with a
9 provider who is currently furnishing services to the individual.
10 An individual shall be eligible under this subparagraph for a
11 Medicare supplement contract issued by the same issuer through
12 which the individual was enrolled at the time of reduction,
13 increase, or discontinuance described above occurs. If no
14 Medicare supplement contract is available from that issuer, the
15 individual shall be eligible for standardized Medicare benefit
16 plans A, B, C, and F (including standardized Medicare
17 supplement high deductible plan F), K, or L from any issuer of
18 one of these plans.

19 (E) The individual demonstrates, in accordance with
20 guidelines established by the secretary, either of the following:

21 (i) The organization offering the plan substantially violated a
22 material provision of the organization's contract under this article
23 in relation to the individual, including the failure to provide on a
24 timely basis medically necessary care for which benefits are
25 available under the plan or the failure to provide the covered care
26 in accordance with applicable quality standards.

27 (ii) The organization, or agent or other entity acting on the
28 organization's behalf, materially misrepresented the plan's
29 provisions in marketing the plan to the individual.

30 (F) The individual meets other exceptional conditions as the
31 secretary may provide.

32 (3) The individual is 65 years of age or older, is enrolled with
33 a Program of All-Inclusive Care for the Elderly (PACE) provider
34 under Section 1894 of the Social Security Act, and circumstances
35 similar to those described in paragraph (2) exist that would
36 permit discontinuance of the individual's enrollment with the
37 provider, if the individual were enrolled in a Medicare
38 Advantage plan.

39 (4) The individual meets both of the following conditions:

40 (A) The individual is enrolled with any of the following:

1 (i) An eligible organization under a contract under Section
2 1876 of the Social Security Act (Medicare cost).

3 (ii) A similar organization operating under demonstration
4 project authority, effective for periods before April 1, 1999.

5 (iii) An organization under an agreement under Section
6 1833(a)(1)(A) of the Social Security Act (health care prepayment
7 plan).

8 (iv) An organization under a Medicare Select policy.

9 (B) The enrollment ceases under the same circumstances that
10 would permit discontinuance of an individual's election of
11 coverage under paragraph (2) or (3).

12 (5) The individual is enrolled under a Medicare supplement
13 contract, and the enrollment ceases because of any of the
14 following circumstances:

15 (A) The insolvency of the issuer or bankruptcy of the
16 nonissuer organization, or other involuntary termination of
17 coverage or enrollment under the contract.

18 (B) The issuer of the contract substantially violated a material
19 provision of the contract.

20 (C) The issuer, or an agent or other entity acting on the
21 issuer's behalf, materially misrepresented the contract's
22 provisions in marketing the contract to the individual.

23 (6) The individual meets both of the following conditions:

24 (A) The individual was enrolled under a Medicare supplement
25 contract and terminates enrollment and subsequently enrolls, for
26 the first time, with any Medicare Advantage organization under a
27 Medicare Advantage plan under Medicare Part C, any eligible
28 organization under a contract under Section 1876 of the Social
29 Security Act (Medicare cost), any similar organization operating
30 under demonstration project authority, any PACE provider under
31 Section 1894 of the Social Security Act, or a Medicare Select
32 policy.

33 (B) The subsequent enrollment under subparagraph (A) is
34 terminated by the individual during any period within the first 12
35 months of the subsequent enrollment (during which the enrollee
36 is permitted to terminate the subsequent enrollment under
37 Section 1851(e) of the federal Social Security Act).

38 (7) The individual upon first becoming eligible for benefits
39 under Medicare Part A at age 65 years of age, enrolls in a
40 Medicare Advantage plan under Medicare Part C or with a PACE

1 provider under Section 1894 of the Social Security Act, and
2 disenrolls from the plan or program not later than 12 months after
3 the effective date of enrollment.

4 (8) The individual while enrolled under a Medicare
5 supplement contract that covers outpatient prescription drugs
6 enrolls in a Medicare Part D plan during the initial enrollment
7 period, terminates enrollment in the Medicare supplement
8 contract, and submits evidence of enrollment in Medicare Part D
9 along with the application for a contract described in paragraph
10 (4) of subdivision (e).

11 (c) (1) In the case of an individual described in paragraph (1)
12 of subdivision (b), the guaranteed issue period begins on the later
13 of the following two dates and ends on the date that is 63 days
14 after the date the applicable coverage terminated:

15 (A) The date the individual receives a notice of termination or
16 cessation of all supplemental health benefits or, if no notice is
17 received, the date of the notice denying a claim because of a
18 termination or cessation of benefits.

19 (B) The date that the applicable coverage terminates or ceases.

20 (2) In the case of an individual described in paragraphs (2),
21 (3), (4), (6), and (7) of subdivision (b) whose enrollment is
22 terminated involuntarily, the guaranteed issue period begins on
23 the date that the individual receives a notice of termination and
24 ends 63 days after the date the applicable coverage is terminated.

25 (3) In the case of an individual described in subparagraph (A)
26 of paragraph (5) of subdivision (b), the guaranteed issue period
27 begins on the earlier of the following two dates and ends on the
28 date that is 63 days after the date the coverage is terminated:

29 (A) The date that the individual receives a notice of
30 termination, a notice of the issuer's bankruptcy or insolvency, or
31 other similar notice if any.

32 (B) The date that the applicable coverage is terminated.

33 (4) In the case of an individual described in paragraph (2), (3),
34 (6), or (7) of, or in subparagraph (B) or (C) of paragraph (5) of,
35 subdivision (b) who disenrolls voluntarily, the guaranteed issue
36 period begins on the date that is 60 days before the effective date
37 of the disenrollment and ends on the date that is 63 days after the
38 effective date of the disenrollment.

39 (5) In the case of an individual described in paragraph (8) of
40 subdivision (b), the guaranteed issue period begins on the date

the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the 60-day period immediately preceding the initial enrollment period for Medicare Part D and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D.

(6) In the case of an individual described in subdivision (b) who is not included in this subdivision, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date of disenrollment.

(d) (1) In the case of an individual described in paragraph (6) of subdivision (b), or deemed to be so described pursuant to this paragraph, whose enrollment with an organization or provider described in subparagraph (A) of paragraph (6) of subdivision (b) is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (6) of subdivision (b).

(2) In the case of an individual described in paragraph (7) of subdivision (b), or deemed to be so described pursuant to this paragraph, whose enrollment with a plan or in a program described in paragraph (7) of subdivision (b) is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (7) of subdivision (b).

(3) For purposes of paragraphs (6) and (7) of subdivision (b), an enrollment of an individual with an organization or provider described in subparagraph (A) of paragraph (6) of subdivision (b), or with a plan or in a program described in paragraph (7) of subdivision (b) shall not be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan, or program.

(e) (1) Under paragraphs (1), (2), (3), (4), and (5) of subdivision (b), an eligible individual is entitled to a Medicare supplement contract that has a benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, or L offered by any issuer.

(2) (A) Under paragraph (6) of subdivision (b), an eligible individual is entitled to the same Medicare supplement contract in which he or she was most recently enrolled, if available from the same issuer. If that contract is not available, the eligible individual is entitled to a Medicare supplement contract that has a benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, or L offered by any issuer.

(B) On and after January 1, 2006, an eligible individual described in this paragraph who was most recently enrolled in a Medicare supplement contract with an outpatient prescription drug benefit, is entitled to a Medicare supplement contract that is available from the same issuer but without an outpatient prescription drug benefit or, at the election of the individual, has a benefit package classified as a Plan A, B, C, F (including high deductible Plan F), K, or L that is offered by any issuer.

(3) Under paragraph (7) of subdivision (b), an eligible individual is entitled to any Medicare supplement contract offered by any issuer.

(4) Under paragraph (8) of subdivision (b), an eligible individual is entitled to a Medicare supplement contract that has a benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, or L and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement contract with outpatient prescription drug coverage.

(f) (1) At the time of an event described in subdivision (b) by which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy or contract, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section and of the obligations of issuers of Medicare supplement contracts under subdivision (a). The notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in subdivision (b) by which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy or contract, or the

1 administrator of the plan, respectively, shall notify the individual
2 of his or her rights under this section, and of the obligations of
3 issuers of Medicare supplement contracts under subdivision (a).
4 The notice shall be communicated within 10 working days of the
5 date the issuer received notification of disenrollment.

6 (g) An issuer shall refund any unearned premium that an
7 enrollee or subscriber paid in advance and shall terminate
8 coverage upon the request of an enrollee or subscriber.

9 SEC. 10. Section 1358.14 of the Health and Safety Code is
10 amended to read:

11 1358.14. (a) (1) (A) With respect to loss ratio standards, a
12 Medicare supplement contract shall not be advertised, solicited,
13 or issued for delivery unless the contract can be expected, as
14 estimated for the entire period for which prepaid or periodic
15 charges are computed to provide coverage, to return to
16 subscribers and enrollees in the form of aggregate benefits under
17 the contract, not including anticipated refunds or credits provided
18 under the contract, at least 75 percent of the aggregate amount of
19 charges earned in the case of group contracts, or at least 65
20 percent of the aggregate amount of charges earned in the case of
21 individual contracts, on the basis of incurred claims or costs of
22 health care services experience and earned prepaid or periodic
23 charges for that period and in accordance with accepted actuarial
24 principles and practices.

25 (B) Loss ratio standards shall be calculated on the basis of
26 incurred health care expenses where coverage is provided by a
27 health care service plan on a service rather than reimbursement
28 basis, and earned prepaid or periodic charges shall be calculated
29 for the period and in accordance with accepted actuarial
30 principles and practices. *Incurred health care expenses where*
31 *coverage is provided by a health care service plan shall not*
32 *include any of the following:*

33 (i) *Home office and overhead costs.*

34 (ii) *Advertising costs.*

35 (iii) *Commissions and other acquisition costs.*

36 (iv) *Taxes.*

37 (v) *Capital costs.*

38 (vi) *Administrative costs.*

39 (vii) *Claims processing costs.*

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to prepaid or periodic charges comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(3) For purposes of applying paragraph (1) of subdivision (a) and paragraph (3) of subdivision ~~(e)~~ (d) of Section 1358.15 only, contracts issued as a result of solicitations of individuals through the mail or by mass media advertising, including both print and broadcast advertising, shall be deemed to be individual contracts.

(b) (1) With respect to refund or credit calculations, an issuer shall collect and file with the director by May 31 of each year the data contained in the applicable reporting form required by the director (NAIC Appendix A) for each type of coverage in a standard Medicare supplement benefit plan.

(2) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type of contract offered by the issuer. For purposes of the refund or credit calculation, experience on contracts issued within the reporting year shall be excluded.

(3) For the purposes of this section, with respect to contracts advertised, solicited, or issued for delivery prior to January 1, 2001, the issuer shall make the refund or credit calculation separately for all individual contracts, including all group contracts subject to an individual loss ratio standard when issued, combined and all other group contracts combined for experience after January 1, 2001. The first report pursuant to paragraph (1) shall be due by May 31, 2003.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds ten dollars (\$10). The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against prepaid or

1 periodic charges due shall be made by September 30 following
2 the experience year upon which the refund or credit is based.

3 (c) An issuer of Medicare supplement contracts shall file
4 annually its prepaid or periodic charges and supporting
5 documentation including ratios of incurred losses to earned
6 prepaid or periodic charges by contract duration for approval by
7 the director in accordance with the filing requirements and
8 procedures prescribed by the director. The supporting
9 documentation shall also demonstrate in accordance with
10 actuarial standards of practice using reasonable assumptions that
11 the appropriate loss ratio standards can be expected to be met
12 over the entire period for which charges are computed. The
13 demonstration shall exclude active life reserves. An expected
14 third-year loss ratio that is greater than or equal to the applicable
15 percentage shall be demonstrated for contracts in force less than
16 three years.

17 As soon as practicable, but prior to the effective date of
18 enhancements in Medicare benefits, every issuer of Medicare
19 supplement contracts shall file with the director, in accordance
20 with applicable filing procedures, all of the following:

21 (1) (A) Appropriate prepaid or periodic charge adjustments
22 necessary to produce loss ratios as anticipated for the current
23 charge for the applicable contracts. The supporting documents
24 necessary to justify the adjustment shall accompany the filing.

25 (B) An issuer shall make prepaid or periodic charge
26 adjustments necessary to produce an expected loss ratio under the
27 contract to conform to minimum loss ratio standards for
28 Medicare supplement contracts and that are expected to result in
29 a loss ratio at least as great as that originally anticipated in the
30 rates used to produce current charges by the issuer for the
31 Medicare supplement contracts. No charge adjustment that would
32 modify the loss ratio experience under the contract other than the
33 adjustments described in this section shall be made with respect
34 to a contract at any time other than upon its renewal date or
35 anniversary date.

36 (C) If an issuer fails to make prepaid or periodic charge
37 adjustments acceptable to the director, the director may order
38 charge adjustments, refunds, or credits deemed necessary to
39 achieve the loss ratio required by this section.

(2) Any appropriate contract amendments needed to accomplish the Medicare supplement contract modifications necessary to eliminate benefit duplications with Medicare. The contract amendments shall provide a clear description of the Medicare supplement benefits provided by the contract.

(d) (1) The director may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a contract form issued before or after the effective date of January 1, 2001, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the director.

(2) The director may conduct a public hearing to gather information if the experience of the form filed under paragraph (1) of subdivision (b) for the previous reporting period is not in compliance with the applicable loss ratio standard.

The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the director.

SEC. 11. Section 1358.15 of the Health and Safety Code is amended to read:

1358.15. (a) An issuer shall not advertise, solicit, or issue for delivery a Medicare supplement contract to a resident of this state unless the contract has been filed with and approved by the director in accordance with filing requirements and procedures prescribed by the director. Until January 1, 2001, or 90 days after approval of Medicare supplement contracts submitted for approval pursuant to this section, whichever is later, issuers may continue to offer and market previously approved Medicare supplement contracts.

(b) *An issuer shall file any riders or amendments to contract forms to delete outpatient prescription drug benefits, as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), only in the state where the contract was issued.*

(c) An issuer shall not use or change prepaid or periodic charges for a Medicare supplement contract unless the charges

1 and supporting documentation have been filed with and approved
2 by the director in accordance with the filing requirements and
3 procedures prescribed by the director.

4 ~~(e)–~~

5 (d) (1) Except as provided in paragraph (2), an issuer shall not
6 file for approval more than one contract of each type for each
7 standard Medicare supplement benefit plan.

8 (2) An issuer may offer, with the approval of the director, up
9 to four additional contracts of the same type for the same
10 standard Medicare supplement benefit plan, one for each of the
11 following cases:

12 (A) The inclusion of new or innovative benefits.

13 (B) The addition of either direct response or agent marketing
14 methods.

15 (C) The addition of either guaranteed issue or underwritten
16 coverage.

17 (D) The offering of coverage to individuals eligible for
18 Medicare by reason of disability.

19 (3) For the purposes of this section, a “type” means an
20 individual contract, a group contract, an individual Medicare
21 Select contract, or a group Medicare Select contract.

22 ~~(d)–~~

23 (e) (1) Except as provided in subdivision (a), an issuer shall
24 continue to make available for purchase any contract issued after
25 January 1, 2001, that has been approved by the director. A
26 contract shall not be considered to be available for purchase
27 unless the issuer has actively offered it for sale in the previous 12
28 months.

29 (A) An issuer may discontinue the availability of a contract if
30 the issuer provides to the director in writing its decision at least
31 30 days prior to discontinuing the availability of the form of the
32 contract. After receipt of the notice by the director, the issuer
33 shall no longer offer for sale the contract in this state.

34 (B) An issuer that discontinues the availability of a contract
35 pursuant to subparagraph (A) shall not file for approval a new
36 contract of the same type for the same standard Medicare
37 supplement benefit plan as the discontinued contract for a period
38 of five years after the issuer provides notice to the director of the
39 discontinuance. The period of discontinuance may be reduced if
40 the director determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this section.

(3) A change in the rating structure or methodology shall be considered a discontinuance under paragraph (1) unless the issuer complies with the following requirements:

(A) The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

(B) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The director may approve a change to the differential—~~which~~ *that* is in the public interest.

~~(e)–~~

~~(f)~~ (1) Except as provided in paragraph (2), the experience of all contracts of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section ~~1358.13~~ 1358.14.

(2) Contracts assumed under an assumption reinsurance agreement shall not be combined with the experience of other contracts for purposes of the refund or credit calculation.

~~(f)–~~

~~(g)~~ (g) A Medicare supplement contract shall be deemed not to be fair, just, or consistent with the objectives of this chapter at all times, and shall not be advertised, solicited, or issued for delivery at any time, except during that period of time, if any, beginning with the date of receipt by the plan of notification by the director that the provisions of the contract are deemed to be fair, just, and consistent with the objectives of this chapter, and ending with the earlier to occur of the events indicated in subdivision ~~(g)~~ (h).

~~(g)–~~

~~(h)~~ (h) The period of time indicated in subdivision ~~(f)~~ (g) shall terminate at the earlier to occur of (1) receipt by the plan of written revocation by the director of the immediate past notification referred to in subdivision ~~(f)~~ (g) specifying the basis for the revocation, (2) the last day of the prepaid or periodic

1 charge calculation period, that in no event may exceed one year,
2 or (3) June 30, of the next succeeding calendar year.

3 ~~(h)~~—

4 (i) An issuer shall secure the director's review of a contract
5 subject to this article by submitting, not less than 30 days prior to
6 any proposed advertising or other use of the contract not already
7 protected by a currently effective notice under subdivision-~~(f)~~ (g),
8 the following for the director's review:

9 (1) A copy of the contract.

10 (2) A copy of the disclosure form.

11 (3) A representation that the contract complies with the
12 provisions of this chapter and the rules adopted thereunder.

13 (4) A completed copy of the "Medicare Supplement Health
14 Care Service Plan Contract Experience Exhibit" set forth in
15 Section 1358.145.

16 (5) A copy of the calculations for the actual or expected loss
17 ratio.

18 (6) Supporting data used in calculating the actual or expected
19 loss ratio as indicated in Section 1358.14.

20 (7) An actuarial certification, as specified in Section 1358.14,
21 of the loss ratio computations.

22 (8) If required by the director, actuarial certification, as
23 specified in Section 1358.14, of the loss ratio computations by
24 one or more unaffiliated actuaries acceptable to the director.

25 (9) An undertaking by the issuer to notify the subscribers in
26 writing within 60 days of decertification, if the contract is
27 identified as a certified contract at the time of sale and later
28 decertified.

29 (10) A signed statement of the president of the issuer or other
30 officer of the issuer designated by that person attesting that the
31 information submitted for review is accurate and complete and
32 does not misrepresent any material fact.

33 ~~(i)~~—

34 (j) An issuer that submits information pursuant to subdivision
35 ~~(h)~~ (i) shall provide any additional information as may be
36 requested by the director to enable the director to conclude that
37 the contract complies with the provisions of this chapter and
38 rules adopted thereunder.

39 ~~(j)~~—

1 (k) For the purposes of this section, the term “decertified,” as
2 applied to a contract, means that the director by written notice
3 has found that the contract no longer complies with the
4 provisions of this chapter and the rules adopted thereunder and
5 has revoked the prior authorization to display on the contract the
6 emblem indicating certification.

7 ~~(k)~~—

8 (l) Benefits designed to cover cost-sharing amounts under
9 Medicare will be changed automatically to coincide with any
10 changes in the applicable Medicare deductible amount and
11 copayment percentage factors and the amount of prepaid charges
12 may be modified, as indicated in paragraph (6) of subdivision (a)
13 of Section 1300.67.4 of *Title 28 of the California Code of*
14 *Regulations*, to correspond with those changes.

15 SEC. 12. Section 1358.17 of the Health and Safety Code is
16 amended to read:

17 1358.17. (a) (1) Medicare supplement contracts shall include
18 a renewal or continuation provision. The language or
19 specifications of the provision shall be consistent with
20 subdivision (a) of Section 1365 and the rules adopted thereunder.
21 The provision shall be appropriately captioned and shall appear
22 on the first page of the contract, and shall include any reservation
23 by the issuer of the right to change prepaid or periodic charges
24 and any automatic renewal increases based on the enrollee’s age.

25 (2) The contract shall contain the provisions required to be set
26 forth by Section 1300.67.4 of *Title 28 of the California Code of*
27 *Regulations*.

28 (b) (1) Except for contract amendments by which the issuer
29 effectuates a request made in writing by the enrollee, exercises a
30 specifically reserved right under a Medicare supplement contract,
31 or is required to reduce or eliminate benefits to avoid duplication
32 of Medicare benefits, all amendments to a Medicare supplement
33 contract after the date of issue or upon reinstatement or renewal
34 that reduce or eliminate benefits or coverage in the contract shall
35 require a signed acceptance by the subscriber. After the date of
36 contract issue, any amendment that increases benefits or
37 coverage with a concomitant increase in prepaid or periodic
38 charges during the contract term shall be agreed to in writing
39 signed by the subscriber, unless the benefits are required by the
40 minimum standards for Medicare supplement contracts, or if the

1 increased benefits or coverage is required by law. ~~Where~~*If* a
2 separate additional charge is made for benefits provided in
3 connection with contract amendments, the charge shall be set
4 forth in the contract.

5 (2) An issuer shall not in any way reduce or eliminate any
6 benefit or coverage under a Medicare supplement contract at any
7 time after the date of entering the contract, including dates of
8 reinstatement or renewal, unless and until the change is
9 voluntarily agreed to in writing signed by the subscriber or
10 enrollee, or is required to reduce or eliminate benefits to avoid
11 duplication of Medicare benefits. The issuer shall not increase
12 benefits or coverage with a concomitant increase in prepaid or
13 periodic charges during the term of the contract unless and until
14 the change is voluntarily agreed to in writing signed by the
15 subscriber or enrollee or unless the increased benefits or
16 coverage is required by law or regulation.

17 (c) Medicare supplement contracts shall not provide for the
18 payment of benefits based on standards described as “usual and
19 customary,” “reasonable and customary,” or words of similar
20 import.

21 (d) If a Medicare supplement contract contains any limitations
22 with respect to preexisting conditions, those limitations shall
23 appear as a separate paragraph of the contract and be labeled as
24 “Preexisting Condition Limitations.”

25 (e) (1) Medicare supplement contracts shall have a notice
26 prominently printed in no less than 10-point uppercase type, on
27 the cover page of the contract or attached thereto stating that the
28 applicant shall have the right to return the contract within 30 days
29 of its receipt via regular mail, and to have any charges refunded
30 in a timely manner if, after examination of the contract, the
31 covered person is not satisfied for any reason. The return shall
32 void the contract from the beginning, and the parties shall be in
33 the same position as if no contract had been issued.

34 (2) For purposes of this section, a timely manner shall be no
35 later than 30 days after the issuer receives the returned contract.

36 (3) If the issuer fails to refund all prepaid or periodic charges
37 paid in a timely manner, then the applicant shall receive interest
38 on the paid charges at the legal rate of interest on judgments as
39 provided in Section 685.010 of the Code of Civil Procedure. The

1 interest shall be paid from the date the issuer received the
2 returned contract.

3 (f) (1) Issuers of health care service plan contracts that
4 provide hospital or medical expense coverage on an expense
5 incurred or indemnity basis to persons eligible for Medicare shall
6 provide to those applicants a guide to health insurance for people
7 with Medicare in the form developed jointly by the National
8 Association of Insurance Commissioners and the ~~Health Care~~
9 ~~Financing Administration~~ *Centers for Medicare and Medicaid*
10 *Services* and in a type size no smaller than 12-point type.
11 Delivery of the guide shall be made whether or not the contracts
12 are advertised, solicited, or issued for delivery as Medicare
13 supplement contracts as defined in this article. Except in the case
14 of direct response issuers, delivery of the guide shall be made to
15 the applicant at the time of application, and acknowledgment of
16 receipt of the guide shall be obtained by the issuer. Direct
17 response issuers shall deliver the guide to the applicant upon
18 request, but not later than at the time the contract is delivered.

19 (2) For the purposes of this section, “form” means the
20 language, format, type size, type proportional spacing, bold
21 character, and line spacing.

22 (g) As soon as practicable, but no later than 30 days prior to
23 the annual effective date of any Medicare benefit changes, an
24 issuer shall notify its enrollees and subscribers of modifications it
25 has made to Medicare supplement contracts in a format
26 acceptable to the director. The notice shall include both of the
27 following:

28 (1) A description of revisions to the Medicare program and a
29 description of each modification made to the coverage provided
30 under the Medicare supplement contract.

31 (2) Inform each enrollee as to when any adjustment in prepaid
32 or periodic charges is to be made due to changes in Medicare.

33 (h) The notice of benefit modifications and any adjustments of
34 prepaid or periodic charges shall be in outline form and in clear
35 and simple terms so as to facilitate comprehension.

36 (i) The notices shall not contain or be accompanied by any
37 solicitation.

38 (j) (1) Issuers shall provide an outline of coverage to all
39 applicants at the time application is presented to the prospective
40 applicant and, except for direct response policies, shall obtain an

acknowledgment of receipt of the outline from the applicant. If an outline of coverage is provided at the time of application and the Medicare supplement contract is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the contract shall accompany the contract when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name:

“NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.”

(2) The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, information about prepaid or periodic charges, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than 12-point type. All benefit plans ~~A-J~~ A-L shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Information about prepaid or periodic charges for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The charge and mode shall be stated for all plans that are offered to the prospective applicant. All possible charges for the prospective applicant shall be illustrated.

(3) The disclosure pages shall be in the language and format described below in no less than 12-point type.

INFORMATION ABOUT PREPAID OR PERIODIC CHARGES

[Insert plan’s name] can only raise your charges if it raises the charge for all contracts like yours in this state. [If the charge is based on the increasing age of the enrollee, include information specifying when charges will change.]

DISCLOSURES

Use this outline to compare benefits and charges among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing the most important features of your Medicare supplement plan contract. This is not the plan contract and only the actual contract provisions will control. You must read the contract itself to understand all of the rights and duties of both you and [insert the health care service plan's name].

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your contract, you may return it to [insert plan's address]. If you send the contract back to us within 30 days after you receive it, we will treat the contract as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing other health coverage, do NOT cancel it until you have actually received your new contract and are sure you want to keep it.

NOTICE

This contract may not fully cover all of your medical costs. Neither [insert the health care service plan's name] nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local social security office or consult "The Medicare Handbook" for further details and limitations applicable to Medicare.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new contract, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your contract and refuse to pay any claims if you leave out or falsify important medical information. [If the contract is guaranteed issue, this paragraph need not appear.] Review the application carefully before you sign it. Be certain that all information has been properly recorded. [The charts displaying the features of each benefit plan offered by the issuer shall use the uniform format and language shown in the charts set forth in Section 17 of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, as most recently adopted by the National Association of Insurance Commissioners. No more than four benefit plans may be shown on one chart. For purposes of illustration, charts for each benefit plan are set forth below. An issuer may use additional benefit plan designations on these charts.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the director.]

(k) Notwithstanding Section 1300.63.2 of Title 10 28 of the California Code of Regulations, no issuer shall combine the evidence of coverage and disclosure form into a single document relating to a contract that supplements Medicare, or is advertised or represented as a supplement to Medicare, with hospital or medical coverage.

(l) The director may adopt regulations to implement this article, including, but not limited to, regulations that specify the required information to be contained in the outline of coverage provided to applicants pursuant to this section, including the format of tables, charts, and other information.

(m) (1) Any health care service plan contract, other than a Medicare supplement contract, a contract issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 ~~U.S.C.A.~~ U.S.C. Sec. 1395 et seq.), a disability income policy, or any other contract identified in subdivision (b) of Section 1358.3, issued for delivery in this state to persons eligible for Medicare, shall notify enrollees under the contract

1 that the contract is not a Medicare supplement contract. The
2 notice shall either be printed or attached to the first page of the
3 outline of coverage delivered to enrollees under the contract, or if
4 no outline of coverage is delivered, to the first page of the
5 contract delivered to enrollees. The notice shall be in no less than
6 12-point type and shall contain the following language:

7
8 “THIS CONTRACT IS NOT A MEDICARE SUPPLEMENT.
9 If you are eligible for Medicare, review the Guide to Health
10 Insurance for People with Medicare available from the
11 company.”
12

13 (2) Applications provided to persons eligible for Medicare for
14 the health insurance contracts described in paragraph (1) shall
15 disclose the extent to which the contract duplicates Medicare in a
16 manner required by the director. The disclosure statement shall
17 be provided as a part of, or together with, the application for the
18 contract.

19 (n) A Medicare supplement contract that does not cover
20 custodial care shall, on the cover page of the outline of
21 coverages, contain the following statement in uppercase type:
22 “THIS POLICY DOES NOT COVER CUSTODIAL CARE IN
23 A SKILLED NURSING CARE FACILITY.”

24 (o) *An issuer shall comply with all notice requirements of the*
25 *Medicare Prescription Drug, Improvement, and Modernization*
26 *Act of 2003 (P.L. 108-173).*

27 SEC. 13. Section 1358.18 of the Health and Safety Code is
28 amended to read:

29 1358.18. In the interest of full and fair disclosure, and to
30 assure the availability of necessary consumer information to
31 potential subscribers or enrollees not possessing a special
32 knowledge of Medicare, health care service plans, or Medicare
33 supplement contracts, an issuer shall comply with the following
34 provisions:

35 (a) Application forms shall include the following questions
36 designed to elicit information as to whether, as of the date of the
37 application, the applicant *currently* has—~~another~~ Medicare
38 supplement, *Medicare Advantage, Medi-Cal coverage, or other*
39 *another* health insurance policy or certificate or plan contract in
40 force or whether a Medicare supplement contract is intended to

1 replace any other disability policy or certificate, or plan contract,
2 presently in force. A supplementary application or other form to
3 be signed by the applicant and solicitor containing those
4 questions and statements may be used.

5
6 “(Statements)
7

8 (1) You do not need more than one Medicare supplement
9 policy or contract.

10 (2) If you purchase this contract, you may want to evaluate
11 your existing health coverage and decide if you need multiple
12 coverages.

13 (3) You may be eligible for benefits under Medi-Cal or
14 medicaid and may not need a Medicare supplement contract.

15 (4) ~~The~~ *If after purchasing this contract you become eligible*
16 *for Medi-Cal, the benefits and premiums under your Medicare*
17 *supplement contract can be suspended, if requested, during your*
18 *entitlement to benefits under Medi-Cal or medicaid for 24*
19 *months. You must request this suspension within 90 days of*
20 *becoming eligible for Medi-Cal or medicaid. If you are no longer*
21 *entitled to Medi-Cal or medicaid, your* *suspended Medicare*
22 *supplement contract or if that is no longer available, a*
23 *substantially equivalent contract, will be reinstituted if requested*
24 *within 90 days of losing Medi-Cal or medicaid eligibility. If the*
25 *Medicare supplement contract provided coverage for outpatient*
26 *prescription drugs and you enrolled in Medicare Part D while*
27 *your contract was suspended, the reinstituted contract will not*
28 *have outpatient prescription drug coverage, but will otherwise be*
29 *substantially equivalent to your coverage before the date of the*
30 *suspension.*

31 (5) *If you are eligible for, and have enrolled in, a Medicare*
32 *supplement contract by reason of disability and you later become*
33 *covered by an employer or union-based group health plan, the*
34 *benefits and premiums under your Medicare supplement contract*
35 *can be suspended, if requested, while you are covered under the*
36 *employer or union-based group health plan. If you suspend your*
37 *Medicare supplement contract under these circumstances and*
38 *later lose your employer or union-based group health plan, your*
39 *suspended Medicare supplement contract or if that is no longer*
40 *available, a substantially equivalent contract, will be reinstituted*

1 *if requested within 90 days of losing your employer or*
 2 *union-based group health plan. If the Medicare supplement*
 3 *contract provided coverage for outpatient prescription drugs and*
 4 *you enrolled in Medicare Part D while your contract was*
 5 *suspended, the reinstituted contract will not have outpatient*
 6 *prescription drug coverage, but will otherwise be substantially*
 7 *equivalent to your coverage before the date of the suspension.*

8 (6) Counseling services are available in ~~your~~ this state to
 9 provide advice concerning your purchase of Medicare
 10 supplement coverage and concerning medical assistance through
 11 the Medi-Cal or medicaid program, including benefits as a
 12 qualified Medicare beneficiary (QMB) and a specified
 13 low-income Medicare beneficiary (SLMB). Information
 14 regarding counseling services may be obtained from the
 15 California Department of Aging.

16
 17 (Questions)
 18

19 *If you lost or are losing other health insurance coverage and*
 20 *received a notice from your prior insurer saying you were*
 21 *eligible for guaranteed issue of a Medicare supplement*
 22 *insurance contract or that you had certain rights to buy such a*
 23 *contract, you may be guaranteed acceptance in one or more of*
 24 *our Medicare supplement plans. Please include a copy of the*
 25 *notice from your prior insurer with your application. PLEASE*
 26 *ANSWER ALL QUESTIONS.*

27 *[Please mark Yes or No below with an "X."]*

28 To the best of your knowledge,

29 ~~(1) Do you have another Medicare supplement policy or~~
 30 ~~certificate, or contract, in force?~~

31 ~~(a) If so, with which company?~~

32 ~~(b) If so, do you intend to replace your current Medicare~~
 33 ~~supplement policy or contract with this contract?~~

34 ~~(2) Do you have any other health insurance coverage that~~
 35 ~~provides benefits similar to this Medicare supplement contract?~~

36 ~~(a) If so, with which company?~~

37 ~~(b) What kind of coverage?~~

38 ~~(3) Are you covered for medical assistance through the~~
 39 ~~Medi-Cal or medicaid program:~~

40 ~~(a) As a specified low-income Medicare beneficiary (SLMB)?~~

1 ~~(b) As a qualified Medicare beneficiary (QMB)?~~

2 ~~(c) For other Medi-Cal or medicaid medical benefits?"~~

3
4 (1) (a) Did you turn 65 years of age in the last 6 months?

5 Yes _____ No _____

6 (b) Did you enroll in Medicare Part B in the last 6 months?

7 Yes _____ No _____

8 (c) If yes, what is the effective date? _____

9 (2) Are you covered for medical assistance through
10 California's Medi-Cal program?

11 NOTE TO APPLICANT: If you have a share of cost under the
12 Medi-Cal program, please answer NO to this question.

13 Yes _____ No _____

14 If yes,

15 (a) Will Medi-Cal pay your premiums for this Medicare
16 supplement contract?

17 Yes _____ No _____

18 (b) Do you receive benefits from Medi-Cal OTHER THAN
19 payments toward your Medicare Part B premium?

20 Yes _____ No _____

21 (3) (a) If you had coverage from any Medicare plan other
22 than original Medicare within the past 63 days (for example, a
23 Medicare Advantage plan or a Medicare HMO or PPO), fill in
24 your start and end dates below. If you are still covered under this
25 plan, leave "END" blank.

26 START __/__/__ END __/__/__

27 (b) If you are still covered under the Medicare plan, do you
28 intend to replace your current coverage with this new Medicare
29 supplement contract?

30 Yes _____ No _____

31 (c) Was this your first time in this type of Medicare plan?

32 Yes _____ No _____

33 (d) Did you drop a Medicare supplement contract to enroll in
34 the Medicare plan?

35 Yes _____ No _____

36 (4) (a) Do you have another Medicare supplement policy or
37 certificate or contract in force?

38 Yes _____ No _____

39 (b) If so, with what company, and what plan do you have
40 [optional for Direct Mailers]?

1 Yes _____ No _____

2 (c) *If so, do you intend to replace your current Medicare*
3 *supplement policy or certificate or contract with this contract?*

4 Yes _____ No _____

5 (5) *Have you had coverage under any other health insurance*
6 *within the past 63 days? (For example, an employer, union, or*
7 *individual plan)*

8 Yes _____ No _____

9 (a) *If so, with what companies and what kind of policy?*

10 _____

11 _____

12 _____

13 _____

14 (b) *What are your dates of coverage under the other policy?*

15 *START* ____/____/____ *END* ____/____/____

16 (If you are still covered under the other policy, leave “END”
17 blank.)

18 (b) Solicitors shall list any other health insurance policies or
19 plan contracts they have sold to the applicant as follows:

20 (1) List policies and contracts sold that are still in force.

21 (2) List policies and contracts sold in the past five years that
22 are no longer in force.

23 (c) An issuer issuing Medicare supplement contracts without a
24 solicitor or solicitor firm (a direct response issuer) shall return to
25 the applicant, upon delivery of the contract, a copy of the
26 application or supplemental forms, signed by the applicant and
27 acknowledged by the issuer.

28 (d) Upon determining that a sale will involve replacement of
29 Medicare supplement coverage, any issuer, other than a direct
30 response issuer, or its agent, shall furnish the applicant, prior to
31 issuance for delivery of the Medicare supplement contract, a
32 notice regarding replacement of Medicare supplement coverage.
33 One copy of the notice signed by the applicant and the agent,
34 except where the coverage is sold without an agent, shall be
35 provided to the applicant and an additional signed copy shall be
36 retained by the issuer. A direct response issuer shall deliver to the
37 applicant at the time of the issuance of the contract the notice
38 regarding replacement of Medicare supplement coverage.

(e) The notice required by subdivision (d) for an issuer shall be provided in substantially the following form in no less than 10-point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT COVERAGE *OR MEDICARE*

ADVANTAGE

(Company name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN
THE FUTURE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate an existing Medicare supplement policy or contract *or Medicare Advantage plan* and replace it with a contract to be issued by [Plan Name]. Your contract to be issued by [Plan Name] will provide 30 days within which you may decide without cost whether you desire to keep the contract. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or contract only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

STATEMENT TO APPLICANT BY PLAN, SOLICITOR,
SOLICITOR FIRM, OR OTHER REPRESENTATIVE:

(1) I have reviewed your current medical or health coverage. The replacement of coverage involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement contract is being purchased for the following reason (check one):

☐ Additional benefits.

☐ No change in benefits, but lower premiums or charges.

☐ Fewer benefits and lower premiums or charges.

☐ *Plan has outpatient prescription drug coverage and applicant is enrolled in Medicare Part D.*

☐ *Disenrollment from a Medicare Advantage Plan. Reasons for disenrollment:*

☐ Other. (please specify) _____

(2) You may not be immediately eligible for full coverage under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present policy or contract.

(3) State law provides that your replacement Medicare supplement contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The plan will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new coverage for similar benefits to the extent that time was spent (depleted) under the original contract.

(4) If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for the plan to deny any future claims and to refund your prepaid or periodic payment as though your contract had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

(5) Do not cancel your present Medicare supplement coverage until you have received your new contract and are sure you want to keep it.

(Signature of Solicitor, Solicitor Firm, or Other Representative)

[Typed Name and Address of Plan, Solicitor, or Solicitor Firm]

(Applicant's Signature)

(Date)

(f) The application form or other consumer information for persons eligible for Medicare and used by an issuer shall contain as an attachment a Medicare supplement buyer's guide in the form approved by the director. The application or other consumer information, containing as an attachment the buyer's guide, shall be mailed or delivered to each applicant applying for that

coverage at or before the time of application and, to establish compliance with this subdivision, the issuer shall obtain an acknowledgment of receipt of the attached buyer's guide from each applicant. No issuer shall make use of or otherwise disseminate any buyer's guide that does not accurately outline current Medicare supplement benefits. No issuer shall be required to provide more than one copy of the buyer's guide to any applicant.

(g) An issuer may comply with the requirement of this section in the case of group contracts by causing the subscriber (1) to disseminate copies of the disclosure form containing as an attachment the buyer's guide to all persons eligible under the group contract at the time those persons are offered the Medicare supplement plan, and (2) collecting and forwarding to the issuer an acknowledgment of receipt of the disclosure form containing as an attachment the buyer's guide from each enrollee.

(h) *An issuer shall not require or request health information from an applicant who is guaranteed issuance of any Medicare supplement coverage.*

SEC. 14. Section 1358.20 of the Health and Safety Code is amended to read:

1358.20. (a) An issuer, directly or through solicitors or other representatives, shall do each of the following:

(1) Establish marketing procedures to ensure that any comparison of Medicare supplement coverage by its solicitors or other representatives will be fair and accurate.

(2) Establish marketing procedures to ensure that excessive coverage is not sold or issued.

(3) Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and contract, the following:

“Notice to buyer: This Medicare supplement contract may not cover all of your medical expenses.”

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant for a Medicare supplement contract already has health care coverage and the types and amounts of that coverage.

(5) Establish auditable procedures for verifying compliance with this subdivision.

(b) In addition to the practices prohibited by this code or any other law, the following acts and practices are prohibited:

(1) Twisting, which means knowingly making any misleading representation or incomplete or fraudulent comparison of any coverages or issuers for the purpose of inducing or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any coverage or to take out coverage with another plan or insurer.

(2) High pressure tactics, which means employing any method of marketing having the effect of or tending to induce the purchase of coverage through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of coverage.

(3) Cold lead advertising, which means making use directly or indirectly of any method of marketing ~~which~~ *that* fails to disclose in a conspicuous manner that a purpose of the method of marketing is the solicitation of coverage and that contact will be made by a health care service plan or its representative.

(c) The terms “Medicare supplement,” “*Medigap*,” “Medicare Wrap-Around” and words of similar import shall not be used unless the contract is issued in compliance with this article. ~~The term “Medigap” shall not be used.~~

SEC. 15. Section 1358.21 of the Health and Safety Code is amended to read:

1358.21. (a) In recommending the purchase or replacement of any Medicare supplement coverage, an issuer or its representative shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(b) Any sale of a Medicare supplement contract that will provide an individual more than one Medicare supplement policy or certificate, or contract, is prohibited.

(c) An issuer shall not issue a Medicare supplement contract to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's coverage under Medicare Part C.

SEC. 16. Section 10192.4 of the Insurance Code is amended to read:

1 10192.4. ~~For~~ *The following definitions apply for the purposes*
2 ~~of this article, the following terms have the following meanings:~~

3 (a) “Applicant” means:

4 (1) The person who seeks to contract for insurance benefits, in
5 the case of an individual Medicare supplement policy.

6 (2) The proposed certificate holder, in the case of a group
7 Medicare supplement policy.

8 (b) “Bankruptcy” means that situation in which a
9 ~~Medicare+Choice~~ *Medicare Advantage* organization that is not
10 an issuer has filed, or has had filed against it, a petition for
11 declaration of bankruptcy and has ceased doing business in the
12 state.

13 (c) “Certificate” means a certificate issued for delivery in this
14 state under a group Medicare supplement policy.

15 (d) “Certificate form” means the form on which the certificate
16 is issued for delivery by the issuer.

17 (e) “Continuous period of creditable coverage” means the
18 period during which an individual was covered by creditable
19 coverage, if during the period of the coverage the individual had
20 no breaks in coverage greater than 63 days.

21 (f) (1) “Creditable coverage” means, with respect to an
22 individual, coverage of the individual provided under any of the
23 following:

24 (A) Any individual or group contract, policy, certificate, or
25 program that is written or administered by a health care service
26 plan, ~~disability~~ *health* insurer, fraternal benefits society,
27 self-insured employer plan, or any other entity, in this state or
28 elsewhere, and that arranges or provides medical, hospital, and
29 surgical coverage not designed to supplement other private or
30 governmental plans. The term includes continuation or
31 conversion coverage.

32 (B) Part A or B of Title XVIII of the federal Social Security
33 Act (Medicare).

34 (C) Title XIX of the federal Social Security Act (medicaid),
35 other than coverage consisting solely of benefits under Section
36 1928 of that act.

37 (D) Chapter 55 of Title 10 of the United States Code
38 (CHAMPUS).

39 (E) A medical care program of the Indian Health Service or of
40 a tribal organization.

1 (F) A state health benefits risk pool.

2 (G) A health plan offered under Chapter 89 of Title 5 of the
3 United States Code (Federal Employees Health Benefits
4 Program).

5 (H) A public health plan as defined in federal regulations
6 authorized by Section 2701(c)(1)(I) of the federal Public Health
7 Service Act, as amended by Public Law 104-191, the federal
8 Health Insurance Portability and Accountability Act of 1996.

9 (I) A health benefit plan under Section 5(e) of the federal
10 Peace Corps Act (Section 2504(e) of Title 22 of the United States
11 Code).

12 (J) Any other publicly sponsored program, provided in this
13 state or elsewhere, of medical, hospital, and surgical care.

14 (K) Any other creditable coverage as defined by subsection (c)
15 of Section 2701 of Title XXVII of the federal Public Health
16 Services Act (42 U.S.C. Sec. 300gg(c)).

17 (2) “Creditable coverage” shall not include one or more, or
18 any combination of, the following:

19 (A) Coverage only for accident or disability income insurance,
20 or any combination thereof.

21 (B) Coverage issued as a supplement to liability insurance.

22 (C) Liability insurance, including general liability insurance
23 and automobile liability insurance.

24 (D) Workers’ compensation or similar insurance.

25 (E) Automobile medical payment insurance.

26 (F) Credit-only insurance.

27 (G) Coverage for onsite medical clinics.

28 (H) Other similar insurance coverage, specified in federal
29 regulations, under which benefits for medical care are secondary
30 or incidental to other insurance benefits.

31 (3) “Creditable coverage” shall not include the following
32 benefits if they are provided under a separate policy, certificate,
33 or contract of insurance or are otherwise not an integral part of
34 the plan:

35 (A) Limited scope dental or vision benefits.

36 (B) Benefits for long-term care, nursing home care, home
37 health care, community-based care, or any combination thereof.

38 (C) Other similar, limited benefits as are specified in federal
39 regulations.

1 (4) “Creditable coverage” shall not include the following
2 benefits if offered as independent, noncoordinated benefits:

3 (A) Coverage only for a specified disease or illness.

4 (B) Hospital indemnity or other fixed indemnity insurance.

5 (5) “Creditable coverage” shall not include the following if
6 offered as a separate policy, certificate, or contract of insurance:

7 (A) Medicare supplemental health insurance as defined under
8 Section 1882(g)(1) of the federal Social Security Act.

9 (B) Coverage supplemental to the coverage provided under
10 Chapter 55 of Title 10 of the United States Code.

11 (C) Similar supplemental coverage provided to coverage under
12 a group health plan.

13 (g) “Employee welfare benefit plan” means a plan, fund, or
14 program of employee benefits as defined in Section 1002 of Title
15 29 of the United States Code (Employee Retirement Income
16 Security Act).

17 (h) “Insolvency” means when an issuer, licensed to transact
18 the business of insurance in this state, has had a final order of
19 liquidation entered against it with a finding of insolvency by a
20 court of competent jurisdiction in the issuer’s state of domicile.

21 (i) “Issuer” includes insurance companies, fraternal benefit
22 societies, and any other entity delivering, or issuing for delivery,
23 Medicare supplement policies or certificates in this state, except
24 entities subject to Article 3.5 (commencing with Section 1358) of
25 Chapter 2.2 of Division 2 of the Health and Safety Code.

26 (j) “Medicare” means the Health Insurance for the Aged Act,
27 Title XVIII of the Social Security Amendments of 1965, as
28 amended.

29 (k) ~~“Medicare+Choice”~~ “*Medicare Advantage Plan*” means a
30 plan of coverage for health benefits under Medicare Part C and
31 includes:

32 (1) Coordinated care plans that provide health care services,
33 including, but not limited to, health care service plans (with or
34 without a point-of-service option), plans offered by
35 provider-sponsored organizations, and preferred provider
36 organizations plans.

37 (2) Medical savings account plans coupled with a contribution
38 into a ~~Medicare+Choice~~ *Medicare Advantage* medical savings
39 account.

(3) ~~Medicare+Choice~~ — *Medicare Advantage* private fee-for-service plans.

(l) “Medicare supplement policy” means a group or individual policy of ~~disability~~ *health* insurance, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C.A. Section 1395mm) or an issued policy under a demonstration project specified in Section 1395ss(g)(1) of Title 42 of the United States Code, ~~which~~ *that* is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare. “*Medicare supplement policy*” *does not include a Medicare Advantage plan established under Medicare Part C, an outpatient prescription drug plan established under Medicare Part D, or a health care prepayment plan that provides benefits pursuant to an agreement under subparagraph (A) of paragraph (1) of subsection (a) of Section 1833 of the Social Security Act.*

(m) “Policy form” means the form on which the policy is issued for delivery by the issuer.

(n) “Secretary” means the Secretary of the United States Department of Health and Human Services.

SEC. 17. Section 10192.5 of the Insurance Code is amended to read:

10192.5. A policy or certificate shall not be advertised, solicited, or issued for delivery as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms that conform to the requirements of this section.

(a) (1) “Accident,” “accidental injury,” or “accidental means” shall be defined to employ “result” language and shall not include words that establish an accidental means test or use words such as “external, violent, visible wounds” or other similar words of description or characterization.

(2) The definition shall not be more restrictive than the following: “injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person that is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force.”

(3) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any

workers' compensation, employer's liability, or similar law, unless prohibited by law.

(b) "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.

(c) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.

(d) (1) "Health care expenses" means expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

(2) "Health care expenses" shall not include any of the following:

- (A) Home office and overhead costs.
- (B) Advertising costs.
- (C) Commissions and other acquisition costs.
- (D) Taxes.
- (E) Capital costs.
- (F) Administrative costs.
- (G) Claims processing costs.

(e) "Hospital" may be defined in relation to its status, facilities, and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

(f) "Medicare" shall be defined in the policy and certificate. "Medicare" may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended," or "Title I, Part I of Public Law 89-97, as enacted by the 89th Congress and popularly known as the Health Insurance for the Aged Act, as amended," or words of similar import.

(g) "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare *Parts A and B*, to the extent recognized as reasonable and medically necessary by Medicare.

(h) "Physician" shall not be defined more restrictively than as defined in the Medicare program.

(i) (1) "Sickness" shall not be defined more restrictively than as follows: "sickness means illness or disease of an insured

1 person that first manifests itself after the effective date of
2 insurance and while the insurance is in force.”

3 (2) The definition may be further modified to exclude
4 sicknesses or diseases for which benefits are provided under any
5 workers’ compensation, occupational disease, employer’s
6 liability, or similar law.

7 SEC. 18. Section 10192.6 of the Insurance Code is amended
8 to read:

9 10192.6. (a) Except for permitted preexisting condition
10 clauses as described in Sections 10192.7 and 10192.8, a policy or
11 certificate shall not be advertised, solicited, or issued for delivery
12 as a Medicare supplement policy if the policy or certificate
13 contains limitations or exclusions on coverage that are more
14 restrictive than those of Medicare.

15 (b) A Medicare supplement policy or certificate shall not use
16 waivers to exclude, limit, or reduce coverage or benefits for
17 specifically named or described preexisting diseases or physical
18 conditions.

19 (c) A Medicare supplement policy or certificate in force shall
20 not contain benefits that duplicate benefits provided by Medicare.

21 *(d) (1) Subject to paragraphs (4) and (5) of subdivision (a) of*
22 *Section 10192.8, a Medicare supplement policy with benefits for*
23 *outpatient prescription drugs that was issued prior to January 1,*
24 *2006, shall be renewed for current policyholders, at the option of*
25 *the policyholder, who do not enroll in Medicare Part D.*

26 *(2) A Medicare supplement policy with benefits for outpatient*
27 *prescription drugs shall not be issued on and after January 1,*
28 *2006.*

29 *(3) On and after January 1, 2006, a Medicare supplement*
30 *policy with benefits for outpatient prescription drugs shall not be*
31 *renewed after the policyholder enrolls in Medicare Part D unless*
32 *both of the following conditions exist:*

33 *(A) The policy is modified to eliminate outpatient prescription*
34 *drug coverage for outpatient prescription drug expenses incurred*
35 *after the effective date of the individual’s coverage under a*
36 *Medicare Part D plan.*

37 *(B) The premium is adjusted to reflect the elimination of*
38 *outpatient prescription drug coverage at the time of enrollment*
39 *in Medicare Part D, accounting for any claims paid if*
40 *applicable.*

1 SEC. 19. Section 10192.8 of the Insurance Code is amended
2 to read:

3 10192.8. The following standards are applicable to all
4 Medicare supplement policies or certificates advertised, solicited,
5 or issued for delivery on or after January 1, 2001. A policy or
6 certificate shall not be advertised, solicited, or issued for delivery
7 as a Medicare supplement policy or certificate unless it complies
8 with these benefit standards.

9 (a) The following general standards apply to Medicare
10 supplement policies and certificates and are in addition to all
11 other requirements of this article:

12 (1) A Medicare supplement policy or certificate shall not
13 exclude or limit benefits for losses incurred more than six months
14 from the effective date of coverage because it involved a
15 preexisting condition. The policy or certificate shall not define a
16 preexisting condition more restrictively than a condition for
17 which medical advice was given or treatment was recommended
18 by or received from a physician within six months before the
19 effective date of coverage.

20 (2) A Medicare supplement policy or certificate shall not
21 indemnify against losses resulting from sickness on a different
22 basis than losses resulting from accidents.

23 (3) A Medicare supplement policy or certificate shall provide
24 that benefits designed to cover cost-sharing amounts under
25 Medicare will be changed automatically to coincide with any
26 changes in the applicable Medicare deductible amount and
27 copayment percentage factors. Premiums may be modified to
28 correspond with those changes.

29 (4) A Medicare supplement policy or certificate shall not
30 provide for termination of coverage of a spouse solely because of
31 the occurrence of an event specified for termination of coverage
32 of the insured, other than the nonpayment of premium.

33 (5) Each Medicare supplement policy shall be guaranteed
34 renewable or noncancelable.

35 (A) The issuer shall not cancel or nonrenew the policy solely
36 on the ground of health status of the individual.

37 (B) The issuer shall not cancel or nonrenew the policy for any
38 reason other than nonpayment of premium or misrepresentation
39 which is shown by the issuer to be material to the acceptance for

1 coverage. The contestability period for Medicare supplement
2 insurance shall be two years.

3 (C) If the Medicare supplement policy is terminated by the
4 master policyholder and is not replaced as provided under
5 subparagraph (E), the issuer shall offer certificate holders an
6 individual Medicare supplement policy that, at the option of the
7 certificate holder, either provides for continuation of the benefits
8 contained in the group policy or provides for benefits that
9 otherwise meet the requirements of one of the standardized
10 policies defined in this article.

11 (D) If an individual is a certificate holder in a group Medicare
12 supplement policy and membership in the group is terminated,
13 the issuer shall either offer the certificate holder the conversion
14 opportunity described in subparagraph (C) or, at the option of the
15 group policyholder, shall offer the certificate holder continuation
16 of coverage under the group policy.

17 (E) (i) If a group Medicare supplement policy is replaced by
18 another group Medicare supplement policy purchased by the
19 same policyholder, the issuer of the replacement policy shall
20 offer coverage to all persons covered under the old group policy
21 on its date of termination. Coverage under the new policy shall
22 not result in any exclusion for preexisting conditions that would
23 have been covered under the group policy being replaced.

24 (ii) If a Medicare supplement policy or certificate replaces
25 another Medicare supplement policy or certificate that has been
26 in force for six months or more, the replacing issuer shall not
27 impose an exclusion or limitation based on a preexisting
28 condition. If the original coverage has been in force for less than
29 six months, the replacing issuer shall waive any time period
30 applicable to preexisting conditions, waiting periods, elimination
31 periods, or probationary periods in the new policy or certificate
32 to the extent the time was spent under the original coverage.

33 (F) *If a Medicare supplement policy eliminates an outpatient*
34 *prescription drug benefit as a result of requirements imposed by*
35 *the Medicare Prescription Drug, Improvement, and*
36 *Modernization Act of 2003 (P.L. 108-173), the policy as modified*
37 *as a result of that act shall be deemed to satisfy the guaranteed*
38 *renewal requirements of this paragraph.*

39 (6) Termination of a Medicare supplement policy or certificate
40 shall be without prejudice to any continuous loss that

commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. *Receipt of Medicare Part D benefits shall not be considered in determining a continuous loss.*

(7) (A) (i) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period, not to exceed 24 months, in which the policyholder or certificate holder has applied for and is determined to be entitled to Medi-Cal or medicaid under Title XIX of the federal Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to assistance. Upon receipt of timely notice, the insurer shall return directly to the insured that portion of the premium attributable to the period of Medi-Cal or medicaid eligibility, subject to adjustment for paid ~~claims~~.

~~(B) If claims.~~ *If suspension occurs and if the policyholder or certificate holder loses entitlement to Medi-Cal or medicaid, the policy or certificate shall be automatically reinstituted, effective as of the date of termination of entitlement, as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement, or equivalent coverage shall be provided if the prior form is no longer available.*

~~(C)~~
(ii) *A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for any period that may be provided by federal regulation if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan, as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act. If suspension occurs and the policyholder or certificate holder loses coverage under the group health plan, the policy or certificate shall be automatically reinstituted, effective as of the*

1 *date of loss of coverage if the policyholder provides notice within*
2 *90 days of the date of the loss of coverage.*

3 (B) Reinstitution of coverages:

4 (i) Shall not provide for any waiting period with respect to
5 treatment of preexisting conditions.

6 (ii) Shall provide for *resumption of coverage* ~~which~~ *that is*
7 *substantially equivalent to coverage in effect before the date of*
8 *suspension. If the suspended Medicare supplement policy*
9 *provided coverage for outpatient prescription drugs, reinstatement*
10 *of the policy for a Medicare Part D enrollee shall not include*
11 *coverage for outpatient prescription drugs but shall otherwise*
12 *provide coverage that is substantially equivalent to the coverage*
13 *in effect before the date of suspension.*

14 (iii) Shall provide for classification of premiums on terms at
15 least as favorable to the policyholder or certificate holder as the
16 premium classification terms that would have applied to the
17 policyholder or certificate holder had the coverage not been
18 suspended.

19 (8) No Medicare supplement policy may limit coverage
20 exclusively to a single disease or affliction.

21 (b) With respect to the standards for basic (core) benefits
22 ~~common to all~~ *for benefit plans A to J, inclusive*, every issuer
23 shall make available a policy or certificate including only the
24 following basic “core” package of benefits to each prospective
25 insured. An issuer may make available to prospective insureds
26 any of the other Medicare supplement insurance benefit plans in
27 addition to the basic core package, but not in lieu of it. However,
28 the benefits described in paragraphs (6) and (7) shall not be
29 offered so long as California is required to disallow these
30 benefits for Medicare beneficiaries by the ~~Health Care Financing~~
31 ~~Administration~~ *Centers for Medicare and Medicaid Services* or
32 other agent of the federal government under Section 1395ss of
33 Title 42 of the United States Code.

34 (1) Coverage of Part A Medicare eligible expenses for
35 hospitalization to the extent not covered by Medicare from the
36 61st day to the 90th day, inclusive, in any Medicare benefit
37 period.

38 (2) Coverage of Part A Medicare eligible expenses incurred
39 for hospitalization to the extent not covered by Medicare for each
40 Medicare lifetime inpatient reserve day used.

(3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of *100 percent of* the Medicare Part A eligible expenses for hospitalization paid at the ~~Medicare diagnostic related group (DRG) day outlier per diem or other~~ appropriate *Medicare* standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations.

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(6) Coverage of the actual cost, up to the legally billed amount, of an annual mammogram as provided in Section 10123.81, to the extent not paid by Medicare.

(7) Coverage of the actual cost, up to the legally billed amount, of an annual cervical cancer screening test as provided in Section 10123.18, to the extent not paid by Medicare.

(c) The following additional benefits shall be included in Medicare supplement benefit plans B to J, inclusive, only as provided by Section 10192.9.

(1) With respect to the Medicare Part A deductible, coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) With respect to skilled nursing facility care, coverage for the actual billed charges up to the coinsurance amount from the 21st day to the 100th day, inclusive, in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.

(3) With respect to the Medicare Part B deductible, coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(4) With respect to 80 percent of the Medicare Part B excess charges, coverage for 80 percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge

1 limitation established by the Medicare program or state law, and
2 the Medicare-approved Part B charge. If the insurer limits
3 payment to a limiting charge, the insurer has the burden to
4 establish that amount as the legal limit.

5 (5) With respect to 100 percent of the Medicare Part B excess
6 charges, coverage for all of the difference between the actual
7 Medicare Part B charge as billed, not to exceed any charge
8 limitation established by the Medicare program or state law, and
9 the Medicare-approved Part B charge. If the insurer limits
10 payment to a limiting charge, the insurer has the burden to
11 establish that amount as the legal limit.

12 (6) With respect to the basic outpatient prescription drug
13 benefit, coverage for 50 percent of outpatient prescription drug
14 charges, after a two hundred fifty dollar (\$250) calendar year
15 deductible, to a maximum of one thousand two hundred fifty
16 dollars (\$1,250) in benefits received by the insured per calendar
17 year, to the extent not covered by Medicare. *On and after*
18 *January 1, 2006, no Medicare supplement policy may be sold or*
19 *issued if it includes a prescription drug benefit.*

20 (7) With respect to the extended outpatient prescription drug
21 benefit, coverage for 50 percent of outpatient prescription drug
22 charges, after a two hundred fifty dollar (\$250) calendar year
23 deductible, to a maximum of three thousand dollars (\$3,000) in
24 benefits received by the insured per calendar year, to the extent
25 not covered by Medicare. *On and after January 1, 2006, no*
26 *Medicare supplement policy may be sold or issued if it includes a*
27 *prescription drug benefit.*

28 (8) With respect to medically necessary emergency care in a
29 foreign country, coverage to the extent not covered by Medicare
30 for 80 percent of the billed charges for Medicare-eligible
31 expenses for medically necessary emergency hospital, physician,
32 and medical care received in a foreign country, which care would
33 have been covered by Medicare if provided in the United States
34 and which care began during the first 60 consecutive days of
35 each trip outside the United States, subject to a calendar year
36 deductible of two hundred fifty dollars (\$250), and a lifetime
37 maximum benefit of fifty thousand dollars (\$50,000). For
38 purposes of this benefit, “emergency care” shall mean care
39 needed immediately because of an injury or an illness of sudden
40 and unexpected onset.

(9) With respect to the following, reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, up to a maximum of one hundred twenty dollars (\$120) annually under this benefit, however, this benefit shall not include payment for any procedure covered by Medicare:

(A) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (B) and patient education to address preventive health care measures.

~~(B) Any one or a combination of the following preventive~~ *The following screening tests or preventive services that are not covered by Medicare, the selection and frequency of which is considered are determined to be medically appropriate: by the attending physician:*

~~(i) Fecal occult blood test or digital rectal examination, or both.~~

~~(ii) Mammogram.~~

~~(iii) Dipstick urinalysis for hematuria, bacteriuria, and proteinuria.~~

~~(iv) Pure tone, air only, hearing screening test, administered or ordered by a physician.~~

~~(v) Serum cholesterol screening every five years.~~

~~(vi) Thyroid function test.~~

~~(vii) Diabetes screening.~~

(C) Influenza vaccine administered at any appropriate time during the year ~~and tetanus and diphtheria booster every 10 years.~~

~~(D) Any other tests or preventive measures determined appropriate by the attending physician.~~

(10) With respect to the at-home recovery benefit, coverage for the actual charges up to forty dollars (\$40) per visit and an annual maximum of one thousand six hundred dollars (\$1,600) per year to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

(A) For purposes of this benefit, the following definitions shall apply:

1 (i) “Activities of daily living” include, but are not limited to,
2 bathing, dressing, personal hygiene, transferring, eating,
3 ambulating, assistance with drugs that are normally
4 self-administered, and changing bandages or other dressings.

5 (ii) “Care provider” means a duly qualified or licensed home
6 health aide or homemaker, or a personal care aide or nurse
7 provided through a licensed home health care agency or referred
8 by a licensed referral agency or licensed nurses registry.

9 (iii) “Home” shall mean any place used by the insured as a
10 place of residence, provided that the place would qualify as a
11 residence for home health care services covered by Medicare. A
12 hospital or skilled nursing facility shall not be considered the
13 insured’s place of residence.

14 (iv) “At-home recovery visit” means the period of a visit
15 required to provide at-home recovery care, without any limit on
16 the duration of the visit, except that each consecutive four hours
17 in a 24-hour period of services provided by a care provider is one
18 visit.

19 (B) With respect to coverage requirements and limitations, the
20 following shall apply:

21 (i) At-home recovery services provided shall be primarily
22 services that assist in activities of daily living.

23 (ii) The insured’s attending physician shall certify that the
24 specific type and frequency of at-home recovery services are
25 necessary because of a condition for which a home care plan of
26 treatment was approved by Medicare.

27 (iii) Coverage is limited to the following:

28 (I) No more than the number and type of at-home recovery
29 visits certified as necessary by the insured’s attending physician.
30 The total number of at-home recovery visits shall not exceed the
31 number of Medicare-approved home health care visits under a
32 Medicare-approved home care plan of treatment.

33 (II) The actual charges for each visit up to a maximum
34 reimbursement of forty dollars (\$40) per visit.

35 (III) One thousand six hundred dollars (\$1,600) per calendar
36 year.

37 (IV) Seven visits in any one week.

38 (V) Care furnished on a visiting basis in the insured’s home.

39 (VI) Services provided by a care provider as defined in
40 subparagraph (A).

1 (VII) At-home recovery visits while the insured is covered
2 under the policy or certificate and not otherwise excluded.

3 (VIII) At-home recovery visits received during the period the
4 insured is receiving Medicare-approved home care services or no
5 more than eight weeks after the service date of the last
6 Medicare-approved home health care visit.

7 (C) Coverage is excluded for the following:

8 (i) Home care visits paid for by Medicare or other government
9 programs.

10 (ii) Care provided by family members, unpaid volunteers, or
11 providers who are not care providers.

12 ~~(11) With respect to new or innovative benefits, an issuer may,~~
13 ~~with the prior approval of the commissioner, offer policies or~~
14 ~~certificates with new or innovative benefits in addition to the~~
15 ~~benefits provided in a policy or certificate that otherwise~~
16 ~~complies with the applicable standards. The new or innovative~~
17 ~~benefits may include benefits that are appropriate to Medicare~~
18 ~~supplement policies, new or innovative, not otherwise available,~~
19 ~~cost-effective, and offered in a manner which is consistent with~~
20 ~~the goal of simplification of Medicare supplement policies.~~

21 *(d) The standardized Medicare supplement benefit plan "K"*
22 *shall consist of the following benefits:*

23 *(1) Coverage of 100 percent of the Medicare Part A hospital*
24 *coinsurance amount for each day used from the 61st to the 90th*
25 *day, inclusive, in any Medicare benefit period.*

26 *(2) Coverage of 100 percent of the Medicare Part A hospital*
27 *coinsurance amount for each Medicare lifetime inpatient reserve*
28 *day used from the 91st to the 150th day, inclusive, in any*
29 *Medicare benefit period.*

30 *(3) Upon exhaustion of the Medicare hospital inpatient*
31 *coverage, including the lifetime reserve days, coverage of 100*
32 *percent of the Medicare Part A eligible expenses for*
33 *hospitalization paid at the applicable prospective payment*
34 *system rate, or other appropriate Medicare standard of payment,*
35 *subject to a lifetime maximum benefit of an additional 365 days.*
36 *The provider shall accept the issuer's payment for this benefit as*
37 *payment in full and shall not bill the insured for any balance.*

38 *(4) With respect to the Medicare Part A deductible, coverage*
39 *for 50 percent of the Medicare Part A inpatient hospital*

1 deductible amount per benefit period until the out-of-pocket
2 limitation described in paragraph (10) is met.

3 (5) With respect to skilled nursing facility care, coverage for
4 50 percent of the coinsurance amount for each day used from the
5 21st day to the 100th day, inclusive, in a Medicare benefit period
6 for posthospital skilled nursing facility care eligible under
7 Medicare Part A until the out-of-pocket limitation described in
8 paragraph (10) is met.

9 (6) With respect to hospice care, coverage for 50 percent of
10 cost sharing for all Medicare Part A eligible expenses and
11 respite care until the out-of-pocket limitation described in
12 paragraph (10) is met.

13 (7) Coverage for 50 percent, under Medicare Part A or B, of
14 the reasonable cost of the first three pints of blood or equivalent
15 quantities of packed red blood cells, as defined under federal
16 regulations, unless replaced in accordance with federal
17 regulations, until the out-of-pocket limitation described in
18 paragraph (10) is met.

19 (8) Except for coverage provided in paragraph (9), coverage
20 for 50 percent of the cost sharing otherwise applicable under
21 Medicare Part B after the policyholder pays the Part B
22 deductible, until the out-of-pocket limitation is met as described
23 in paragraph (10).

24 (9) Coverage of 100 percent of the cost sharing for Medicare
25 Part B preventive services, after the policyholder pays the
26 Medicare Part B deductible.

27 (10) Coverage of 100 percent of all cost sharing under
28 Medicare Parts A and B for the balance of the calendar year
29 after the individual has reached the out-of-pocket limitation on
30 annual expenditures under Medicare Parts A and B of four
31 thousand dollars (\$4,000) in 2006, indexed each year by the
32 appropriate inflation adjustment specified by the secretary.

33 (e) The standardized Medicare supplement benefit plan "L"
34 shall consist of the following benefits:

35 (1) The benefits described in paragraphs (1), (2), (3), and (9)
36 of subdivision (d).

37 (2) With respect to the Medicare Part A deductible, coverage
38 for 75 percent of the Medicare Part A inpatient hospital
39 deductible amount per benefit period until the out-of-pocket
40 limitation described in paragraph (8) is met.

(3) *With respect to skilled nursing facility care, coverage for 75 percent of the coinsurance amount for each day used from the 21st day to the 100th day, inclusive, in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation described in paragraph (8) is met.*

(4) *With respect to hospice care, coverage for 75 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation described in paragraph (8) is met.*

(5) *Coverage for 75 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations, until the out-of-pocket limitation described in paragraph (8) is met.*

(6) *Except for coverage provided in paragraph (7), coverage for 75 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation described in paragraph (8) is met.*

(7) *Coverage for 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible.*

(8) *Coverage of 100 percent of the cost sharing for Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of two thousand dollars (\$2,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary.*

SEC. 20. Section 10192.9 of the Insurance Code is amended to read:

10192.9. (a) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in subdivision (b) of Section 10192.8.

(b) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted by

1 ~~paragraph (11) of subdivision (e) of Section 10192.8 subdivision~~
2 ~~(f) and by Section 10192.10.~~

3 (c) Benefit plans shall be uniform in structure, language,
4 designation and format to the standard benefit plans A to J,
5 inclusive, listed in subdivision (e), and shall conform to the
6 definitions in Section 10192.4. Each benefit shall be structured in
7 accordance with the format provided in subdivisions (b)~~and~~, (c),
8 ~~(d), and (e)~~ of Section 10192.8 and list the benefits in the order
9 listed in subdivision (e). For purposes of this section, “structure,
10 language, and format” means style, arrangement, and overall
11 content of a benefit.

12 (d) An issuer may use, in addition to the benefit plan
13 designations required in subdivision (c), other designations to the
14 extent permitted by law.

15 (e) With respect to the makeup of benefit plans, the following
16 shall apply:

17 (1) Standardized Medicare supplement benefit plan A shall be
18 limited to the basic (core) benefit common to all benefit plans, as
19 defined in subdivision (b) of Section 10192.8.

20 (2) Standardized Medicare supplement benefit plan B shall
21 include only the following: the core benefit, plus the Medicare
22 Part A deductible as defined in paragraph (1) of subdivision (c)
23 of Section 10192.8.

24 (3) Standardized Medicare supplement benefit plan C shall
25 include only the following: the core benefit, plus the Medicare
26 Part A deductible, skilled nursing facility care, Medicare Part B
27 deductible, and medically necessary emergency care in a foreign
28 country as defined in paragraphs (1), (2), (3), and (8) of
29 subdivision (c) of Section 10192.8, respectively.

30 (4) Standardized Medicare supplement benefit plan D shall
31 include only the following: the core benefit, plus the Medicare
32 Part A deductible, skilled nursing facility care, medically
33 necessary emergency care in a foreign country, and the at-home
34 recovery benefit as defined in paragraphs (1), (2), (8), and (10) of
35 subdivision (c) of Section 10192.8, respectively.

36 (5) Standardized Medicare supplement benefit plan E shall
37 include only the following: the core benefit, plus the Medicare
38 Part A deductible, skilled nursing facility care, medically
39 necessary emergency care in a foreign country, and preventive

1 medical care as defined in paragraphs (1), (2), (8), and (9) of
2 subdivision (c) of Section 10192.8, respectively.

3 (6) Standardized Medicare supplement benefit plan F shall
4 include only the following: the core benefit, plus the Medicare
5 Part A deductible, the skilled nursing facility care, the Medicare
6 Part B deductible, 100 percent of the Medicare Part B excess
7 charges, and medically necessary emergency care in a foreign
8 country as defined in paragraphs (1), (2), (3), (5), and (8) of
9 subdivision (c) of Section 10192.8, respectively.

10 (7) Standardized Medicare supplement benefit high deductible
11 plan F shall include only the following: 100 percent of covered
12 expenses following the payment of the annual high deductible
13 plan F deductible. The covered expenses include the core benefit,
14 plus the Medicare Part A deductible, skilled nursing facility care,
15 the Medicare Part B deductible, 100 percent of the Medicare Part
16 B excess charges, and medically necessary emergency care in a
17 foreign country as defined in paragraphs (1), (2), (3), (5), and (8)
18 of subdivision (c) of Section 10192.8, respectively. The annual
19 high deductible plan F deductible shall consist of out-of-pocket
20 expenses, other than premiums, for services covered by the
21 Medicare supplement plan F policy, and shall be in addition to
22 any other specific benefit deductibles. The annual high
23 deductible Plan F deductible shall be one thousand five hundred
24 dollars (\$1,500) for 1998 and 1999, and shall be based on the
25 calendar year, as adjusted annually thereafter by the secretary to
26 reflect the change in the Consumer Price Index for all urban
27 consumers for the 12-month period ending with August of the
28 preceding year, and rounded to the nearest multiple of ten dollars
29 (\$10).

30 (8) Standardized Medicare supplement benefit plan G shall
31 include only the following: the core benefit, plus the Medicare
32 Part A deductible, skilled nursing facility care, 80 percent of the
33 Medicare Part B excess charges, medically necessary emergency
34 care in a foreign country, and the at-home recovery benefit as
35 defined in paragraphs (1), (2), (4), (8), and (10) of Section
36 10192.8, respectively.

37 (9) Standardized Medicare supplement benefit plan H shall
38 consist of only the following: the core benefit, plus the Medicare
39 Part A deductible, skilled nursing facility care, basic outpatient
40 prescription drug benefit, and medically necessary emergency

1 care in a foreign country as defined in paragraphs (1), (2), (6),
2 and (8) of Section 10192.8, respectively. *The outpatient*
3 *prescription drug benefit shall not be included in a Medicare*
4 *supplement policy sold on or after January 1, 2006.*

5 (10) Standardized Medicare supplement benefit plan I shall
6 consist of only the following: the core benefit, plus the Medicare
7 Part A deductible, skilled nursing facility care, 100 percent of the
8 Medicare Part B excess charges, basic outpatient prescription
9 drug benefit, medically necessary emergency care in a foreign
10 country, and at-home recovery benefit as defined in paragraphs
11 (1), (2), (5), (6), (8), and (10) of subdivision (c) of Section
12 10192.8, respectively. *The outpatient prescription drug benefit*
13 *shall not be included in a Medicare supplement policy sold on or*
14 *after January 1, 2006.*

15 (11) Standardized Medicare supplement benefit plan J shall
16 consist of only the following: the core benefit, plus the Medicare
17 Part A deductible, skilled nursing facility care, Medicare Part B
18 deductible, 100 percent of the Medicare Part B excess charges,
19 extended outpatient prescription drug benefit, medically
20 necessary emergency care in a foreign country, preventive
21 medical care, and at-home recovery benefit as defined in
22 paragraphs (1), (2), (3), (5), (7), (8), (9), and (10) of subdivision
23 (c) of Section 10192.8, respectively. *The outpatient prescription*
24 *drug benefit shall not be included in a Medicare supplement*
25 *policy sold on or after January 1, 2006.*

26 (12) Standardized Medicare supplement benefit high
27 deductible plan J shall consist of only the following: 100 percent
28 of covered expenses following the payment of the annual high
29 deductible plan J deductible. The covered expenses include the
30 core benefit, plus the Medicare Part A deductible, skilled nursing
31 facility care, Medicare Part B deductible, 100 percent of the
32 Medicare Part B excess charges, extended outpatient prescription
33 drug benefit, medically necessary emergency care in a foreign
34 country, preventive medical care benefit, and at-home recovery
35 benefit as defined in paragraphs (1), (2), (3), (5), (7), (8), (9), and
36 (10) of subdivision (c) of Section 10192.8, respectively. The
37 annual high deductible plan J deductible shall consist of
38 out-of-pocket expenses, other than premiums, for services
39 covered by the Medicare supplement plan J policy, and shall be
40 in addition to any other specific benefit deductibles. The annual

deductible shall be one thousand five hundred dollars (\$1,500) for 1998 and 1999, and shall be based on a calendar year, as adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10). *The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold on or after January 1, 2006.*

(13) Standardized Medicare supplement benefit plan K shall consist of only those benefits described in subdivision (d) of Section 10192.8.

(14) Standardized Medicare supplement benefit plan L shall consist of only those benefits described in subdivision (e) of Section 10192.8.

(f) An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, that are not otherwise available and that are cost-effective and offered in a manner that is consistent with the goal of simplification of Medicare supplement policies. On and after January 1, 2006, the innovative benefit shall not include an outpatient prescription drug benefit.

SEC. 21. Section 10192.10 of the Insurance Code is amended to read:

10192.10. (a) (1) This section shall apply to Medicare Select policies and certificates, as defined in this section.

(2) A policy or certificate shall not be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

(b) For the purposes of this section:

(1) “Appeal” means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

(2) “Complaint” means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

1 (3) “Medicare Select issuer” means an issuer offering, seeking
2 to offer, advertising, marketing, soliciting, or issuing a Medicare
3 Select policy or certificate.

4 (4) “Medicare Select policy” or “Medicare Select certificate”
5 mean respectively a Medicare supplement policy or certificate
6 that contains restricted network provisions.

7 (5) “Network provider” means a provider of health care, or a
8 group of providers of health care, which has entered into a
9 written agreement with the issuer or other entity to provide
10 benefits insured under a Medicare Select policy.

11 (6) “Restricted network provision” means any provision ~~which~~
12 *that* conditions the payment of benefits, in whole or in part, on
13 the use of network providers.

14 (7) “Service area” means the geographic area approved by the
15 commissioner within which an issuer is authorized to offer a
16 Medicare Select policy.

17 (8) “Grievance” means a written complaint registered by an
18 individual for resolution under the formal grievance procedure,
19 which may involve, but is not limited to, the administration,
20 claims practices or provision of services by the issuer or its
21 network providers.

22 (9) “Medicare Select coverage” means Medicare supplement
23 coverage through a preferred provider organization or any other
24 type of restricted network, which coverage has been approved by
25 the commissioner under this section.

26 (10) “Preferred provider organization” means a health care
27 provider or an entity contracting with health care providers that
28 (A) establishes alternative or discounted rates of payment, (B)
29 offers the insureds certain advantages for selecting the member
30 providers, or (C) withholds from the insureds certain advantages
31 if they choose providers other than the member providers.
32 Organizations regulated as Medicare Select include, but are not
33 limited to, provider groups, hospital marketing plans, and
34 organizations that are formed or operated by insurers or
35 third-party administrators.

36 (c) The commissioner may authorize an issuer to offer a
37 Medicare Select policy or certificate pursuant to this section if
38 the commissioner finds that the issuer has satisfied all of the
39 requirements of this section.

1 (d) A Medicare Select issuer shall not issue a Medicare Select
2 policy or certificate in this state until its plan of operation has
3 been approved by the commissioner.

4 (e) A Medicare Select issuer shall file a proposed plan of
5 operation with the commissioner in a format prescribed by the
6 commissioner. The plan of operation shall contain at least the
7 following information:

8 (1) Evidence that all covered services that are subject to
9 restricted network provisions are available and accessible
10 through network providers, including a demonstration of all of
11 the following:

12 (A) That services can be provided by network providers with
13 reasonable promptness with respect to geographic location, hours
14 of operation, and afterhour care. The hours of operation and
15 availability of afterhour care shall reflect usual practice in the
16 local area. Geographic availability shall reflect the usual travel
17 times within the community.

18 (B) That the number of network providers in the service area
19 is sufficient, with respect to current and expected policyholders,
20 as to either of the following:

21 (i) To deliver adequately all services that are subject to a
22 restricted network provision.

23 (ii) To make appropriate referrals.

24 (C) There are written agreements with network providers
25 describing specific responsibilities.

26 (D) Emergency care is available 24 hours per day and seven
27 days per week.

28 (E) In the case of covered services that are subject to a
29 restricted network provision and are provided on a prepaid basis,
30 that there are written agreements with network providers
31 prohibiting the providers from billing or otherwise seeking
32 reimbursement from or recourse against any individual insured
33 under a Medicare Select policy or certificate.

34 This subparagraph shall not apply to supplemental charges or
35 coinsurance amounts as stated in the Medicare Select policy or
36 certificate.

37 (2) A statement or map providing a clear description of the
38 service area.

39 (3) A description of the appeal or grievance procedure to be
40 utilized.

- 1 (4) A description of the quality assurance program, including
2 all of the following:
- 3 (A) The formal organizational structure.
- 4 (B) The written criteria for selection, retention, and removal of
5 network providers.
- 6 (C) The procedures for evaluating quality of care provided by
7 network providers, and the process to initiate corrective action
8 when warranted.
- 9 (5) A list and description, by specialty, of the network
10 providers.
- 11 (6) Copies of the written information proposed to be used by
12 the issuer to comply with subdivision (i).
- 13 (7) Any other information requested by the commissioner.
- 14 (f) (1) A Medicare Select issuer shall file any proposed
15 changes to the plan of operation, except for changes to the list of
16 network providers, with the commissioner prior to implementing
17 the changes. Changes shall be considered approved by the
18 commissioner after 30 days unless specifically disapproved.
- 19 (2) An updated list of network providers shall be filed at the
20 commissioner's request, but at least quarterly.
- 21 (g) A Medicare Select policy or certificate shall not restrict
22 payment for covered services provided by nonnetwork providers
23 if:
- 24 (1) The services are for symptoms requiring emergency care
25 or are immediately required for an unforeseen illness, injury, or
26 condition.
- 27 (2) It is not reasonable to obtain services through a network
28 provider.
- 29 (h) A Medicare Select policy or certificate shall provide
30 payment for full coverage under the policy for covered services
31 that are not available through network providers.
- 32 (i) A Medicare Select issuer shall make full and fair disclosure
33 in writing of the provisions, restrictions, and limitations of the
34 Medicare Select policy or certificate to each applicant. This
35 disclosure shall include at least the following:
- 36 (1) An outline of coverage sufficient to permit the applicant to
37 compare the coverage and premiums of the Medicare Select
38 policy or certificate with both of the following:
- 39 (A) Other Medicare supplement policies or certificates offered
40 by the issuer.

1 (B) Other Medicare Select policies or certificates.

2 (2) A description, including address, telephone number, and
3 hours of operation, of the network providers, including primary
4 care physicians, specialty physicians, hospitals, and other
5 providers.

6 (3) A description of the restricted network provisions,
7 including payments for coinsurance and deductibles when
8 providers other than network providers are utilized. *The*
9 *description shall inform the applicant that expenses incurred*
10 *when using out-of-network providers are excluded from the*
11 *out-of-pocket annual limit in benefit plans K and L, unless the*
12 *policy or certificate provides otherwise.*

13 (4) A description of coverage for emergency and urgently
14 needed care and other out-of-service area coverage.

15 (5) A description of limitations on referrals to restricted
16 network providers and to other providers.

17 (6) A description of the policyholder's or certificate holder's
18 rights to purchase any other Medicare supplement policy or
19 certificate otherwise offered by the issuer.

20 (7) A description of the Medicare Select issuer's quality
21 assurance, grievance, and appeal procedure.

22 (j) Prior to the sale of a Medicare Select policy or certificate, a
23 Medicare Select issuer shall obtain from the applicant a signed
24 and dated form stating that the applicant has received the
25 information provided pursuant to subdivision (i) and that the
26 applicant understands the restrictions of the Medicare Select
27 policy or certificate. Acknowledgments shall be maintained by
28 the insurer for at least five years in accordance with Section
29 10508.

30 (k) A Medicare Select issuer shall have and use procedures for
31 hearing complaints and resolving written appeals and grievances
32 from the insureds. The procedures shall be aimed at mutual
33 agreement for settlement and may include arbitration procedures.

34 (1) The appeal and grievance procedure shall be described in
35 the policy and certificates and in the outline of coverage.

36 (2) At the time the policy or certificate is issued, the issuer
37 shall provide detailed information to the policyholder or
38 certificate holder describing how an appeal or grievance may be
39 registered with the issuer.

(3) Appeals or grievances shall be considered in a timely manner and shall be transmitted to appropriate fiduciaries who have authority to fully investigate the issue and take corrective action.

(4) If an appeal or grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of an appeal or grievance.

(6) The issuer shall report no later than each March 31st to the commissioner regarding its appeal or grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of appeals or grievances filed in the past year and a summary of the subject, nature, and resolution of those appeals or grievances.

(7) Detailed information describing in writing how to register an appeal or grievance shall be provided to the insured prior to, or simultaneously with, the issuance of the policy or certificate.

(8) The issuer shall maintain records of each appeal or grievance for at least five years.

(l) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

(m) (1) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six months, unless the replacement policy or certificate includes ~~prescription drug coverage or at-home recovery~~ benefits that were not included in the Medicare Select coverage.

(2) For the purposes of this subdivision, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a

significant benefit means coverage for the Medicare Part A deductible, ~~coverage for prescription drugs~~, coverage for at-home recovery services, or coverage for Medicare Part B excess charges.

(n) Medicare Select policies and certificates shall provide for continuation of coverage in the event the commissioner determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer ~~which~~ *that* has comparable or lesser benefits and ~~which~~ *that* does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this subdivision, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, ~~coverage for prescription drugs~~, coverage for at-home recovery services, or coverage for Medicare Part B excess charges.

(o) A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services for the purpose of evaluating the Medicare Select program.

(p) The commissioner may grant special Medicare Select status to plans of guaranteed renewable Medicare supplement coverage provided through a preferred provider organization, which plans were offered to the public or in force before the effective date of this section, if the commissioner determines that the applicants will receive benefits and consumer protections that are substantially equivalent to those in other Medicare Select plans identified in this section, and if the issuer satisfies the following requirements:

1 (1) The issuer shall apply within one year of the effective date
2 of this section by submitting to the commissioner the following
3 items:

4 (A) The current plan of operation as defined in subdivision (e).

5 (B) If the written disclosures of subdivision (i) have not been
6 delivered to each applicant as required, the issuer's plan to
7 accomplish full disclosure to every insured and to achieve
8 substantial compliance with subdivision (j).

9 (C) The issuer's statement of intent to comply with
10 subdivision (f).

11 (D) If the plan of operation does not comply with the
12 standards of subdivision (g), (h), (k), (l), or (m), the issuer's plan
13 for achieving substantial compliance with these subdivisions for
14 every insured.

15 (2) The issuer shall alter the plan as requested by the
16 commissioner in order to bring the plan into substantial
17 compliance with Medicare Select standards.

18 (3) The issuer shall issue disclosures or other notices to its
19 insureds regarding its status as Medicare Select as ordered by the
20 commissioner.

21 (4) The issuer shall provide data as provided in subdivision
22 (o).

23 SEC. 22. Section 10192.11 of the Insurance Code is amended
24 to read:

25 10192.11. (a) An issuer shall not deny or condition the
26 issuance or effectiveness of any Medicare supplement policy or
27 certificate available for sale in this state, nor discriminate in the
28 pricing of a policy or certificate because of the health status,
29 claims experience, receipt of health care, or medical condition of
30 an applicant in the case of an application for a policy or
31 certificate that is submitted prior to or during the six-month
32 period beginning with the first day of the first month in which an
33 individual is ~~both 65 years of age or older and is enrolled for~~
34 ~~benefits under Medicare Part B. Each Medicare supplement~~
35 ~~policy and certificate currently available from an issuer shall be~~
36 ~~made available to all applicants who qualify under this~~
37 ~~subdivision and are 65 years of age or older. Medicare~~
38 ~~supplement contracts A, B, C, F, and at least one~~
39 ~~letter-designated plan (H, I, or J, at the discretion of the issuer)~~
40 ~~that includes coverage for prescription medications, if currently~~

1 ~~available from an issuer, shall be made available to any applicant~~
 2 ~~who qualifies under this subdivision who is 64 years of age or~~
 3 ~~younger and who does not have End-Stage Renal Disease.~~ This
 4 section and Section 10192.12 do not prohibit an issuer in
 5 determining premium rates from treating applicants who are
 6 under 65 years of age and are eligible for Medicare Part B as a
 7 separate risk classification. This section shall not be construed as
 8 preventing the exclusion of benefits for preexisting conditions as
 9 defined in paragraph (1) of subdivision (a) of Section 10192.8.

10 (b) (1) If an applicant qualifies under subdivision (a) and
 11 submits an application during the time period referenced in
 12 subdivision (a) and, as of the date of application, has had a
 13 continuous period of creditable coverage of at least six months,
 14 the issuer shall not exclude benefits based on a preexisting
 15 condition.

16 (2) If the applicant qualifies under subdivision (a) and submits
 17 an application during the time period referenced in subdivision
 18 (a) and, as of the date of application, has had a continuous period
 19 of creditable coverage that is less than six months, the issuer
 20 shall reduce the period of any preexisting condition exclusion by
 21 the aggregate of the period of creditable coverage applicable to
 22 the applicant as of the enrollment date. The manner of the
 23 reduction under this subdivision shall be as specified by the
 24 commissioner.

25 (c) Except as provided in subdivision (b) and Section
 26 10192.23, subdivision (a) shall not be construed as preventing the
 27 exclusion of benefits under a policy, during the first six months,
 28 based on a preexisting condition for which the policyholder or
 29 certificate holder received treatment or was otherwise diagnosed
 30 during the six months before the coverage became effective.

31 ~~(d) An individual enrolled in Medicare by reason of disability~~
 32 ~~will be entitled to open enrollment described in this section for~~
 33 ~~six months after he or she enrolled in Medicare Part B, or if~~
 34 ~~notified retroactively of his or her eligibility for Medicare, for six~~
 35 ~~months following notice of eligibility.~~ Every issuer shall make
 36 available to every applicant qualified for open enrollment all
 37 policies and certificates offered by that issuer at the time of
 38 application. Issuers shall not discourage sales during the open
 39 enrollment period by any means, including the altering of the
 40 commission structure.

~~There shall be a one-time open enrollment period of 90 days commencing on January 1, 2004, for all individuals eligible for Medicare by reason of disability who do not have End-Stage Renal Disease and who did not use the prior one-time open enrollment that commenced on January 1, 2001. Notice of this one-time open enrollment right shall be publicized on the Web sites of the Department of Managed Health Care, the Department of Insurance, and the Department of Aging, through those departments' written materials directed to Medicare beneficiaries, and by HICAP, beginning January 1, 2003.~~

(e) (1) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section for six months following:

~~(1)~~

(A) Receipt of a notice of termination or, if no notice is received, the effective date of termination from any employer-sponsored health plan including an employer-sponsored retiree health plan.

~~(2)~~

(B) Receipt of a notice of loss of eligibility due to the divorce or death of a spouse or, if no notice is received, the effective date of loss of eligibility due to the divorce or death of a spouse, from any employer-sponsored health plan including an employer-sponsored retiree health plan.

~~(3)~~

(C) Termination of health care services for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.

(2) For purposes of this subdivision, "employer-sponsored retiree health plan" includes any coverage for medical expenses that is directly or indirectly sponsored or established by an employer for employees or retirees, their spouses, dependents, or other included insureds.

(f) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section if the individual was covered under a policy, certificate, or contract providing Medicare supplement coverage but that coverage terminated

because the individual established residence at a location not served by the plan.

(g) An individual whose coverage was terminated by a Medicare ~~managed-care~~ *Advantage* plan shall be entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation, for any Medicare supplement coverage provided by Medicare supplement ~~insurers~~ *issuers* and available on a guaranteed basis under state and federal law or regulation for persons terminated by their Medicare ~~managed-care~~ *Advantage* plan.

(h) An individual shall be entitled to an annual open enrollment period lasting 30 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement policy, ~~with the exception of a Medicare Select policy,~~ that offers benefits equal to or lesser than those provided by the previous coverage. During this open enrollment period, no issuer that falls under this provision shall deny or condition the issuance or effectiveness of Medicare supplement coverage, nor discriminate in the pricing of coverage, because of health status, claims experience, receipt of health care, or medical condition of the individual if, at the time of the open enrollment period, the individual is covered under another Medicare supplement policy or contract. An issuer shall notify a policyholder of his or her rights under this subdivision at least 30 and no more than 60 days before the beginning of the open enrollment period.

(i) *An individual enrolled in Medicare Part B is entitled to open enrollment described in this section upon being notified that he or she is no longer eligible for benefits under the Medi-Cal program.*

SEC. 23. Section 10192.12 of the Insurance Code is repealed.

~~10192.12. (a) (1) With respect to the guaranteed issue of a Medicare supplement policy, eligible persons are those individuals described in subdivision (b) who apply to enroll under the policy not later than 63 days after the date of the termination of enrollment described in subdivision (b), and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.~~

~~(2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subdivision (c) that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of that Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under that Medicare supplement policy.~~

~~(3) Issuers shall issue coverage with an effective date not later than the date of termination of previous benefits or the date requested on the application, but in no event earlier than the date of application for coverage. Issuers shall issue coverage so that there is no duplication or overlap of coverage.~~

~~(b) An eligible person is an individual described in any of the following paragraphs:~~

~~(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates, the individual loses his or her eligibility to continue benefits due to the divorce or death of a spouse, or the plan ceases to provide some, all, or substantially all of those supplemental health benefits to the individual and the employer no longer provides the individual with insurance that covers all of the payment for the Part B 20-percent coinsurance.~~

~~(2) The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan Medicare Part C, and any of the following apply:~~

~~(A) The organization's or plan's certification, under this part, has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.~~

~~(B) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act, where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in~~

standards under Section 1856 of that act, or the plan is terminated for all individuals within a residence area.

(C) The individual demonstrates, in accordance with guidelines established by the commissioner, either of the following:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under this article in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide the covered care in accordance with applicable quality standards.

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual.

(D) The Medicare+Choice plan in which the individual is enrolled reduces any of its benefits or increases the amount of cost-sharing or discontinues for other than good cause relating to the quality of care under the plan, a provider who is currently furnishing services to the individual. However, with respect to eligibility under this subparagraph, an individual shall be eligible only for a Medicare supplement policy issued by the same insurer through which the individual is enrolled at the time the reduction, increase, or discontinuance described above occurs. The change to another policy may occur no more frequently than every two years.

(E) The individual meets other exceptional conditions as the commissioner may provide.

(3) The individual meets both of the following conditions:

(A) The individual is enrolled with any of the following:

(i) An eligible organization under a contract under Section 1876 of the federal Social Security Act (Medicare risk or cost).

(ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999.

(iii) An organization under an agreement under Section 1833(a)(1)(A) of the federal Social Security Act (health care prepayment plan).

(iv) An organization under a Medicare Select policy.

(B) The individual's enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under the first sentence of

~~Section 1851(e)(4) of the federal Social Security Act as delineated in paragraph (2) of subdivision (b):~~

~~(4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because of the following: the insolvency of the issuer or bankruptcy of the nonissuer organization; the involuntary termination of coverage or enrollment under the policy; the issuer of the policy substantially violated a material provision of the policy; or the issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.~~

~~(5) The individual meets both of the following conditions:~~

~~(A) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under Medicare Part C, any eligible organization under a contract under Section 1876 of the federal Social Security Act (Medicare risk or cost), any similar organization operating under demonstration project authority, an organization under an agreement under Section 1833(a)(1)(A) of the federal Social Security Act (health care prepayment plan), or a Medicare Select policy.~~

~~(B) The subsequent enrollment under subparagraph (A) is terminated by the enrollee during any period within the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate the subsequent enrollment under Section 1851(e) of the federal Social Security Act).~~

~~(6) The individual, upon first becoming eligible for benefits under Medicare Part A who postpones enrollment in Medicare Part A or Part B while eligible for employer-sponsored coverage, enrolls in a Medicare+Choice plan under Medicare Part C, and disenrolls from the plan by not later than 12 months after the effective date of enrollment.~~

~~(e) (1) Under paragraphs (1), (2), (3), and (4) of subdivision (b), eligible persons are entitled to a Medicare supplement policy that has a benefit package classified as plan A, B, C, F, and at least one letter-designated plan (H, I, or J, at the discretion of the issuer) that includes coverage for prescription medications, if currently available from an issuer.~~

~~(2) Under paragraph (5) of subdivision (b), eligible persons are entitled to the same Medicare supplement policy in which they were most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in paragraph (1) of subdivision (c).~~

~~(3) Under paragraph (6) of subdivision (b), eligible persons are entitled to any Medicare supplement policy offered by any issuer.~~

~~(d) (1) At the time of an event described in subdivision (b) because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subdivision (a). That notice shall be communicated contemporaneously with the notification of termination.~~

~~(2) At the time of an event described in subdivision (b) because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subdivision (a). That notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.~~

~~(e) Issuers shall refund any unearned monthly premium paid in advance and terminate coverage upon the request of any insured person.~~

SEC. 24. Section 10192.12 is added to the Insurance Code, to read:

10192.12. (a) (1) With respect to the guaranteed issue of a Medicare supplement policy, eligible persons are those individuals described in subdivision (b) who seek to enroll under the policy during the period specified in subdivision (c), and who submit evidence of the date of termination or disenrollment or enrollment in Medicare Part D with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not take any of the following actions:

(A) Deny or condition the issuance or effectiveness of a Medicare supplement policy described in subdivision (e) that is offered and is available for issuance to new enrollees by the issuer.

(B) Discriminate in the pricing of that Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition.

(C) Impose an exclusion of benefits based on a preexisting condition under that Medicare supplement policy.

(b) An eligible person is an individual described in any of the following paragraphs:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan either terminates or ceases to provide all of those supplemental health benefits to the individual.

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, and any of the following circumstances apply:

(A) The certification of the organization or plan has been terminated.

(B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.

(C) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary. Those changes in circumstances shall not include termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856, or the plan is terminated for all individuals within a residence area.

(D) The Medicare Advantage plan in which the individual is enrolled reduces any of its benefits or increases the amount of cost sharing or discontinues for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to the individual.

1 An individual shall be eligible under this subparagraph for a
2 Medicare supplement policy issued by the same issuer through
3 which the individual was enrolled at the time of reduction,
4 increase, or discontinuance described above occurs. If no
5 Medicare supplement policy is available from that issuer, the
6 individual shall be eligible for standardized Medicare benefit
7 plans A, B, C, and F (including standardized Medicare
8 supplement high deductible plan F), K, or L from any issuer of
9 one of these plans.

10 (E) The individual demonstrates, in accordance with
11 guidelines established by the secretary, either of the following:

12 (i) The organization offering the plan substantially violated a
13 material provision of the organization's contract under this article
14 in relation to the individual, including the failure to provide on a
15 timely basis medically necessary care for which benefits are
16 available under the plan or the failure to provide the covered care
17 in accordance with applicable quality standards.

18 (ii) The organization, or agent or other entity acting on the
19 organization's behalf, materially misrepresented the plan's
20 provisions in marketing the plan to the individual.

21 (F) The individual meets other exceptional conditions as the
22 secretary may provide.

23 (3) The individual is 65 years of age or older, is enrolled with
24 a Program of All-Inclusive Care for the Elderly (PACE) provider
25 under Section 1894 of the Social Security Act, and circumstances
26 similar to those described in paragraph (2) exist that would
27 permit discontinuance of the individual's enrollment with the
28 provider, if the individual were enrolled in a Medicare
29 Advantage plan.

30 (4) The individual meets both of the following conditions:

31 (A) The individual is enrolled with any of the following:

32 (i) An eligible organization under a contract under Section
33 1876 of the Social Security Act (Medicare cost).

34 (ii) A similar organization operating under demonstration
35 project authority, effective for periods before April 1, 1999.

36 (iii) An organization under an agreement under Section
37 1833(a)(1)(A) of the Social Security Act (health care prepayment
38 plan).

39 (iv) An organization under a Medicare Select policy.

1 (B) The enrollment ceases under the same circumstances that
2 would permit discontinuance of an individual's election of
3 coverage under paragraph (2) or (3).

4 (5) The individual is enrolled under a Medicare supplement
5 policy, and the enrollment ceases because of any of the following
6 circumstances:

7 (A) The insolvency of the issuer or bankruptcy of the
8 nonissuer organization, or other involuntary termination of
9 coverage or enrollment under the policy.

10 (B) The issuer of the policy substantially violated a material
11 provision of the policy.

12 (C) The issuer, or an agent or other entity acting on the
13 issuer's behalf, materially misrepresented the policy's provisions
14 in marketing the policy to the individual.

15 (6) The individual meets both of the following conditions:

16 (A) The individual was enrolled under a Medicare supplement
17 policy and terminates enrollment and subsequently enrolls, for
18 the first time, with any Medicare Advantage organization under a
19 Medicare Advantage plan under Medicare Part C, any eligible
20 organization under a contract under Section 1876 of the Social
21 Security Act (Medicare cost), any similar organization operating
22 under demonstration project authority, any PACE provider under
23 Section 1894 of the Social Security Act, or a Medicare Select
24 policy.

25 (B) The subsequent enrollment under subparagraph (A) is
26 terminated by the individual during any period within the first 12
27 months of the subsequent enrollment (during which the enrollee
28 is permitted to terminate the subsequent enrollment under
29 Section 1851(e) of the federal Social Security Act).

30 (7) The individual upon first becoming eligible for benefits
31 under Medicare Part A at age 65 years of age, enrolls in a
32 Medicare Advantage plan under Medicare Part C or with a PACE
33 provider under Section 1894 of the Social Security Act, and
34 disenrolls from the plan or program not later than 12 months after
35 the effective date of enrollment.

36 (8) The individual while enrolled under a Medicare
37 supplement policy that covers outpatient prescription drugs
38 enrolls in a Medicare Part D plan during the initial enrollment
39 period, terminates enrollment in the Medicare supplement policy,
40 and submits evidence of enrollment in Medicare Part D along

1 with the application for a policy described in paragraph (4) of
2 subdivision (e).

3 (c) (1) In the case of an individual described in paragraph (1)
4 of subdivision (b), the guaranteed issue period begins on the later
5 of the following two dates and ends on the date that is 63 days
6 after the date the applicable coverage terminates:

7 (A) The date the individual receives a notice of termination or
8 cessation of all supplemental health benefits or, if no notice is
9 received, the date of the notice denying a claim because of a
10 termination or cessation of benefits.

11 (B) The date that the applicable coverage terminates or ceases.

12 (2) In the case of an individual described in paragraphs (2),
13 (3), (4), (6), and (7) of subdivision (b) whose enrollment is
14 terminated involuntarily, the guaranteed issue period begins on
15 the date that the individual receives a notice of termination and
16 ends 63 days after the date the applicable coverage is terminated.

17 (3) In the case of an individual described in subparagraph (A)
18 of paragraph (5) of subdivision (b), the guaranteed issue period
19 begins on the earlier of the following two dates and ends on the
20 date that is 63 days after the date the coverage is terminated:

21 (A) The date that the individual receives a notice of
22 termination, a notice of the issuer's bankruptcy or insolvency, or
23 other similar notice if any.

24 (B) The date that the applicable coverage is terminated.

25 (4) In the case of an individual described in paragraph (2), (3),
26 (6), or (7) of, or in subparagraph (B) or (C) of paragraph (5) of,
27 subdivision (b) who disenrolls voluntarily, the guaranteed issue
28 period begins on the date that is 60 days before the effective date
29 of the disenrollment and ends on the date that is 63 days after the
30 effective date of the disenrollment.

31 (5) In the case of an individual described in paragraph (8) of
32 subdivision (b), the guaranteed issue period begins on the date
33 the individual receives notice pursuant to Section 1882(v)(2)(B)
34 of the Social Security Act from the Medicare supplement issuer
35 during the 60-day period immediately preceding the initial
36 enrollment period for Medicare Part D and ends on the date that
37 is 63 days after the effective date of the individual's coverage
38 under Medicare Part D.

39 (6) In the case of an individual described in subdivision (b)
40 who is not included in this subdivision, the guaranteed issue

1 period begins on the effective date of disenrollment and ends on
2 the date that is 63 days after the effective date of disenrollment.

3 (d) (1) In the case of an individual described in paragraph (6)
4 of subdivision (b), or deemed to be so described pursuant to this
5 paragraph, whose enrollment with an organization or provider
6 described in subparagraph (A) of paragraph (6) of subdivision (b)
7 is involuntarily terminated within the first 12 months of
8 enrollment and who, without an intervening enrollment, enrolls
9 with another such organization or provider, the subsequent
10 enrollment shall be deemed to be an initial enrollment described
11 in paragraph (6) of subdivision (b).

12 (2) In the case of an individual described in paragraph (7) of
13 subdivision (b), or deemed to be so described pursuant to this
14 paragraph, whose enrollment with a plan or in a program
15 described in paragraph (7) of subdivision (b) is involuntarily
16 terminated within the first 12 months of enrollment and who,
17 without an intervening enrollment, enrolls in another such plan or
18 program, the subsequent enrollment shall be deemed to be an
19 initial enrollment described in paragraph (7) of subdivision (b).

20 (3) For purposes of paragraphs (6) and (7) of subdivision (b),
21 an enrollment of an individual with an organization or provider
22 described in subparagraph (A) of paragraph (6) of subdivision
23 (b), or with a plan or in a program described in paragraph (7) of
24 subdivision (b) shall not be deemed to be an initial enrollment
25 under this paragraph after the two-year period beginning on the
26 date on which the individual first enrolled with such an
27 organization, provider, plan, or program.

28 (e) (1) Under paragraphs (1), (2), (3), (4), and (5) of
29 subdivision (b), an eligible individual is entitled to a Medicare
30 supplement policy that has a benefit package classified as Plan A,
31 B, C, F (including a high deductible Plan F), K, or L offered by
32 any issuer.

33 (2) (A) Under paragraph (6) of subdivision (b), an eligible
34 individual is entitled to the same Medicare supplement policy in
35 which he or she was most recently enrolled, if available from the
36 same issuer. If that policy is not available, the eligible individual
37 is entitled to a Medicare supplement policy that has a benefit
38 package classified as Plan A, B, C, F (including a high deductible
39 Plan F), K, or L offered by any issuer.

(B) On and after January 1, 2006, an eligible individual described in this paragraph who was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, is entitled to a Medicare supplement policy that is available from the same issuer but without an outpatient prescription drug benefit or, at the election of the individual, has a benefit package classified as a Plan A, B, C, F (including high deductible Plan F), K, or L that is offered by any issuer.

(3) Under paragraph (7) of subdivision (b), an eligible individual is entitled to any Medicare supplement policy offered by any issuer.

(4) Under paragraph (8) of subdivision (b), an eligible individual is entitled to a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, or L and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

(f) (1) At the time of an event described in subdivision (b) by which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section and of the obligations of issuers of Medicare supplement policies under subdivision (a). The notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in subdivision (b) by which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subdivision (a). The notice shall be communicated within 10 working days of the date the issuer received notification of disenrollment.

(g) An issuer shall refund any unearned premium that an insured paid in advance and shall terminate coverage upon the request of an insured.

SEC. 25. Section 10192.14 of the Insurance Code is amended to read:

10192.14. (a) (1) (A) With respect to loss ratio standards, a Medicare supplement policy form or certificate form shall not be advertised, solicited, or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy form or certificate form at least 75 percent of the aggregate amount of premiums earned in the case of group policies, or at least 65 percent of the aggregate amount of premiums earned in the case of individual policies.

(B) Loss ratio standards shall be calculated on the basis of incurred claims experience, and earned premiums shall be calculated for the period and in accordance with accepted actuarial principles and practices.

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(3) For purposes of applying paragraph (1) of subdivision (a) and paragraph (3) of subdivision ~~(c)~~ (d) of Section 10192.15 only, policies issued as a result of solicitations of individuals through the mail or by mass media advertising, including both print and broadcast advertising, shall be deemed to be individual policies.

(b) (1) With respect to refund or credit calculations, an issuer shall collect and file with the commissioner by May 31 of each year the data contained in the applicable reporting form required by the commissioner for each type of coverage in a standard Medicare supplement benefit plan.

(2) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(3) For the purposes of this section, with respect to policies or certificates advertised, solicited, or issued for delivery prior to January 1, 2001, the issuer shall make the refund or credit calculation separately for all individual policies, including all group policies subject to an individual loss ratio standard when issued, combined and all other group policies combined for experience after January 1, 2001. The first report pursuant to paragraph (1) shall be due by May 31, 2003.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(c) An issuer of Medicare supplement policies and certificates shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner and this code. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio that is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.

As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare

1 supplement policies or certificates shall file with the
2 commissioner, in accordance with applicable filing procedures,
3 all of the following:

4 (1) (A) Appropriate premium adjustments necessary to
5 produce loss ratios as anticipated for the current premium for the
6 applicable policies or certificates. The supporting documents
7 necessary to justify the adjustment shall accompany the filing.

8 (B) An issuer shall make premium adjustments necessary to
9 produce an expected loss ratio under the policy or certificate to
10 conform to minimum loss ratio standards for Medicare
11 supplement policies and that are expected to result in a loss ratio
12 at least as great as that originally anticipated in the rates used to
13 produce current premiums by the issuer for the Medicare
14 supplement policies or certificates. No premium adjustment that
15 would modify the loss ratio experience under the policy other
16 than the adjustments described in this section shall be made with
17 respect to a policy at any time other than upon its renewal date or
18 anniversary date.

19 (C) If an issuer fails to make premium adjustments acceptable
20 to the commissioner, the commissioner may order premium
21 adjustments, refunds, or premium credits deemed necessary to
22 achieve the loss ratio required by this section.

23 (2) Any appropriate riders, endorsements, or policy forms
24 needed to accomplish the Medicare supplement policy or
25 certificate modifications necessary to eliminate benefit
26 duplications with Medicare. The riders, endorsements, or policy
27 forms shall provide a clear description of the Medicare
28 supplement benefits provided by the policy or certificate.

29 (d) The commissioner may conduct a public hearing to gather
30 information concerning a request by an issuer for an increase in a
31 rate for a policy form or certificate form issued before or after the
32 effective date of January 1, 2001, if the experience of the form
33 for the previous reporting period is not in compliance with the
34 applicable loss ratio standard. The determination of compliance
35 is made without consideration of any refund or credit for the
36 reporting period. Public notice of the hearing shall be furnished
37 in a manner deemed appropriate by the commissioner.

38 SEC. 26. Section 10192.15 of the Insurance Code is amended
39 to read:

10192.15. (a) An issuer shall not advertise, solicit, or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner. Master policies issued outside California shall be filed for informational purposes along with the certificates. Until January 1, 2001, or 90 days after approval of Medicare supplement policies or certificates submitted for approval pursuant to this section, whichever is later, issuers may continue to offer and market previously approved Medicare supplement policies or certificates.

~~(b) (1) An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits, as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), only with the commissioner in the state where the policy or certificate was issued.~~

(c) (1) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

(2) Paragraph (1) of subdivision (b) of Section 10290 shall not apply to Medicare supplement insurance forms or rates. However, the commissioner may authorize in writing, for good cause only, the limited use of a form or rates after that form or the rates have been filed with the commissioner for 60 days and have not otherwise been acted upon.

~~(e)~~

(d) (1) Except as provided in paragraph (2), an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(2) An issuer may offer, with the approval of the commissioner, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

(A) The inclusion of new or innovative benefits.

(B) The addition of either direct response or agent marketing methods.

1 (C) The addition of either guaranteed issue or underwritten
2 coverage.

3 (D) The offering of coverage to individuals eligible for
4 Medicare by reason of disability.

5 (3) For the purposes of this section, a “type” means an
6 individual policy, a group policy, an individual Medicare Select
7 policy, or a group Medicare Select policy.

8 ~~(d)~~

9 (e) (1) Except as provided in subdivision (a), an issuer shall
10 continue to make available for purchase any policy form or
11 certificate form issued after January 1, 2001, that has been
12 approved by the commissioner. A policy form or certificate form
13 shall not be considered to be available for purchase unless the
14 issuer has actively offered it for sale in the previous 12 months.

15 (A) An issuer may discontinue the availability of a policy form
16 or certificate form if the issuer provides to the commissioner in
17 writing its decision at least 60 days prior to discontinuing the
18 availability of the form of the policy or certificate. After receipt
19 of the notice by the commissioner, the issuer shall no longer offer
20 for sale the policy form or certificate form in this state.

21 (B) An issuer that discontinues the availability of a policy
22 form or certificate form pursuant to subparagraph (A) shall not
23 file for approval a new policy form or certificate form of the
24 same type for the same standard Medicare supplement benefit
25 plan as the discontinued form for a period of five years after the
26 issuer provides notice to the commissioner of the discontinuance.
27 The period of discontinuance may be reduced if the
28 commissioner determines that a shorter period is appropriate.

29 (2) The sale or other transfer of Medicare supplement business
30 to another issuer shall be considered a discontinuance for the
31 purposes of this subdivision.

32 (3) A change in the rating structure or methodology shall be
33 considered a discontinuance under paragraph (1) unless the issuer
34 complies with the following requirements:

35 (A) The issuer provides an actuarial memorandum, in a form
36 and manner prescribed by the commissioner, describing the
37 manner in which the revised rating methodology and resultant
38 rates differ from the existing rating methodology and existing
39 rates. The commissioner may approve the change if it is in the
40 public interest.

(B) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential ~~which~~ *that* is in the public interest. The commissioner may approve a change to the differential if it is in the public interest.

~~(e)~~

(f) (1) Except as provided in paragraph (2), the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section ~~10192.13~~ *10192.14*.

(2) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

SEC. 27. Section 10192.17 of the Insurance Code is amended to read:

10192.17. (a) Medicare supplement policies and certificates shall include a renewal, continuation, or conversion provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(b) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after the date of issue or upon reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement ~~which~~ *that* increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by

1 law. ~~Where~~ *If* a separate additional premium is charged for
2 benefits provided in connection with riders or endorsements, the
3 premium charge shall be set forth in the policy.

4 (c) Medicare supplement policies or certificates shall not
5 provide for the payment of benefits based on standards described
6 as “usual and customary,” “reasonable and customary,” or words
7 of similar import.

8 (d) If a Medicare supplement policy or certificate contains any
9 limitations with respect to preexisting conditions, those
10 limitations shall appear as a separate paragraph of the policy and
11 be labeled as “Preexisting Condition Limitations.”

12 (e) (1) Medicare supplement policies and certificates shall
13 have a notice prominently printed on the first page of the policy
14 or certificate, and of the outline of coverage, or attached thereto,
15 in no less than 10-point uppercase type, stating in substance that
16 the policyholder or certificate holder shall have the right to return
17 the policy or certificate, via regular mail, within 30 days of
18 receiving it, and to have the full premium refunded if, after
19 examination of the policy or certificate, the insured person is not
20 satisfied for any reason. The return shall void the contract from
21 the beginning, and the parties shall be in the same position as if
22 no contract had been issued.

23 (2) For purposes of this section, a timely manner shall be no
24 later than 30 days after the issuer receives the returned contract.

25 (3) If the issuer fails to refund all prepaid or periodic charges
26 paid in a timely manner, then the applicant shall receive interest
27 on the paid charges at the legal rate of interest on judgments as
28 provided in Section 685.010 of the Code of Civil Procedure. The
29 interest shall be paid from the date the issuer received the
30 returned contract.

31 (f) (1) Issuers of ~~disability~~ *health* insurance policies,
32 certificates, or contracts that provide hospital or medical expense
33 coverage on an expense incurred or indemnity basis, other than
34 incidentally, to persons eligible for Medicare shall provide to
35 those applicants a Guide to Health Insurance for People with
36 Medicare in the form developed jointly by the National
37 Association of Insurance Commissioners and the ~~Health Care~~
38 ~~Financing Administration~~ *Centers for Medicare and Medicaid*
39 *Services* and in a type size no smaller than 12-point type.
40 Delivery of the guide shall be made whether or not the policies or

certificates are advertised, solicited, or issued for delivery as Medicare supplement policies or certificates as defined in this article. Except in the case of direct response issuers, delivery of the guide shall be made to the applicant at the time of application, and acknowledgment of receipt of the guide shall be obtained by the issuer. Direct response issuers shall deliver the guide to the applicant upon request, but not later than at the time the policy is delivered.

(2) For the purposes of this section, “form” means the language, format, type size, type proportional spacing, bold character, and line spacing.

(g) As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement policies or certificates in a format acceptable to the commissioner. The notice shall include both of the following:

(1) A description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate.

(2) Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

(h) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(i) The notices shall not contain or be accompanied by any solicitation.

(j) (1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of the outline from the applicant. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name:

1 “NOTICE: Read this outline of coverage carefully. It is not
2 identical to the outline of coverage provided upon application
3 and the coverage originally applied for has not been issued.”
4

5 (2) The outline of coverage provided to applicants pursuant to
6 this section consists of four parts: a cover page, premium
7 information, disclosure pages, and charts displaying the features
8 of each benefit plan offered by the issuer. The outline of
9 coverage shall be in the language and format prescribed below in
10 no less than 12-point type. All plans ~~A-J~~ A-L shall be shown on
11 the cover page, and the plans that are offered by the issuer shall
12 be prominently identified. Premium information for plans that are
13 offered shall be shown on the cover page or immediately
14 following the cover page and shall be prominently displayed. The
15 premium and mode shall be stated for all plans that are offered to
16 the prospective applicant. All possible premiums for the
17 prospective applicant shall be illustrated.

18 (3) The commissioner may adopt regulations to implement this
19 article, including, but not limited to, regulations that specify the
20 required information to be contained in the outline of coverage
21 provided to applicants pursuant to this section, including the
22 format of tables, charts, and other information.

23 (k) (1) Any disability insurance policy or certificate, a basic,
24 catastrophic or major medical expense policy, or single premium
25 nonrenewal policy or certificate issued to persons eligible for
26 Medicare, other than a Medicare supplement policy, a policy
27 issued pursuant to a contract under Section 1876 of the federal
28 Social Security Act (~~42 U.S.C.A.~~ *U.S.C.* Sec. 1395 et seq.), a
29 disability income policy, or any other policy identified in
30 subdivision (b) of Section 10192.3, advertised, solicited, or
31 issued for delivery in this state to persons eligible for Medicare,
32 shall notify insureds under the policy that the policy is not a
33 Medicare supplement policy or certificate. The notice shall either
34 be printed or attached to the first page of the outline of coverage
35 delivered to insureds under the policy, or if no outline of
36 coverage is delivered, to the first page of the policy or certificate
37 delivered to insureds. The notice shall be in no less than 12-point
38 type and shall contain the following language:
39

1 “THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE
2 SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible
3 for Medicare, review the Guide to Health Insurance for People
4 with Medicare available from the company.”
5

6 (2) Applications provided to persons eligible for Medicare for
7 the disability insurance policies or certificates described in
8 paragraph (1) shall disclose the extent to which the policy
9 duplicates Medicare in a manner required by the commissioner.
10 The disclosure statement shall be provided as a part of, or
11 together with, the application for the policy or certificate.

12 (1) Insurers issuing Medicare supplement policies or
13 certificates for delivery in California shall provide an outline of
14 coverage to all applicants at the time of presentation for
15 examination or sale as provided in Section 10605, and in no case
16 later than at the time the application is made. Except for direct
17 response policies, insurers shall obtain a written acknowledgment
18 of receipt of the outline from the applicant.

19 Any advertisement that is not a presentation for examination or
20 sale as defined in subdivision (e) of Section 10601 shall contain
21 a notice in no less than 10-point uppercase type that an outline of
22 coverage is available upon request. The insurer or agent that
23 receives any request for an outline of coverage shall provide an
24 outline of coverage to the person making the request within 14
25 days of receipt of the request.

26 (2) If an outline of coverage is provided at or before the time
27 of application and the Medicare supplement policy or certificate
28 is issued on a basis that would require revision of the outline, a
29 substitute outline of coverage properly describing the policy or
30 certificate shall accompany the policy or certificate when it is
31 delivered and contain the following statement, in no less than
32 12-point type, immediately above the name:
33

34 “NOTICE: Read this outline of coverage carefully. It is not
35 identical to the outline of coverage provided upon application
36 and the coverage originally applied for has not been issued.”
37

38 (3) The outline of coverage shall be in the language and
39 format prescribed in this subdivision in no less than 12-point
40 type, and shall include the following items in the order prescribed

below. Titles, as set forth below in paragraphs (B) to (H), inclusive, shall be capitalized, centered, and printed in boldface type. The outline of coverage shall include the items, and in the same order, specified in the chart set forth in ~~paragraph (4) of subdivision (C) of~~ Section 17 of the Model Regulation to implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, as adopted by the National Association of Insurance Commissioners ~~on July 30, 1991~~ in 2004.

(A) The cover page shall contain the ~~10-plan (A through J) chart~~ *12-plan (A-L) charts*. The plans offered by the insurer shall be clearly identified. Innovative benefits shall be explained in a manner approved by the commissioner. The text shall read:

“Medicare supplement insurance can be sold in only ~~10~~ 12 standard plans. This chart shows the benefits included in each plan. Every insurance company must offer Plan A. Some plans may not be available.

The BASIC BENEFITS included in ALL plans are:

Hospitalization: Medicare Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical expenses: Medicare Part B coinsurance (usually 20 percent of the Medicare-approved amount).

Blood: First three pints of blood each year.

Mammogram: One annual screening to the extent not covered by Medicare.

Cervical cancer test: One annual screening.”

[Reference to the mammogram and cervical cancer test shall not be included so long as California is required to disallow them for Medicare beneficiaries by the ~~Health Care Financing Administration~~ *Centers for Medicare and Medicaid Services* or other agent of the federal government under 42 U.S.C. Sec. 1395ss.]

(B) PREMIUM INFORMATION. Premium information for plans that are offered by the insurer shall be shown on, or immediately following, the cover page and shall be clearly and prominently displayed. The premium and mode shall be stated for all offered plans. All possible premiums for the prospective applicant shall be illustrated in writing. If the premium is based on the increasing age of the insured, information specifying when

1 and how premiums will change shall be clearly illustrated in
2 writing. The text shall state: “We [the insurer’s name] can only
3 raise your premium if we raise the premium for all policies like
4 yours in California.”

5 (C) The text shall state: “Use this outline to compare benefits
6 and premiums among policies.”

7 (D) READ YOUR POLICY VERY CAREFULLY. The text
8 shall state: “This is only an outline describing your policy’s most
9 important features. The policy is your insurance contract. You
10 must read the policy itself to understand all of the rights and
11 duties of both you and your insurance company.”

12 (E) THIRTY-DAY RIGHT TO RETURN THIS POLICY. The
13 text shall state: “If you find that you are not satisfied with your
14 policy, you may return it to [insert the insurer’s address]. If you
15 send the policy back to us within 30 days after you receive it, we
16 will treat the policy as if it has never been issued and return all of
17 your payments.”

18 (F) POLICY REPLACEMENT. The text shall read: “If you
19 are replacing another health insurance policy, do NOT cancel it
20 until you have actually received your new policy and are sure
21 you want to keep it.”

22 (G) DISCLOSURES. The text shall read: “This policy may
23 not fully cover all of your medical costs.” “Neither this company
24 nor any of its agents are connected with Medicare.” “This outline
25 of coverage does not give all the details of Medicare coverage.
26 Contact your local social security office or consult “The
27 Medicare Handbook” for more details.” “For additional
28 information concerning policy benefits, contact the Health
29 Insurance Counseling and Advocacy Program (HICAP) or your
30 agent. Call the HICAP toll-free telephone number,
31 1-800-434-0222, for a referral to your local HICAP office.
32 HICAP is a service provided free of charge by the State of
33 California.”

34 The disclosure required by this paragraph, as revised by
35 amendments made during the 1996 portion of the 1995–96
36 Regular Session, shall be included in the required disclosure
37 form no later than January 1, 1998.

38 (H) [For policies that are not guaranteed issue] COMPLETE
39 ANSWERS ARE IMPORTANT. The text shall read: “When you
40 fill out the application for a new policy, be sure to answer

1 truthfully and completely all questions about your medical and
2 health history. The company may have the right to cancel your
3 policy and refuse to pay any claims if you leave out or falsify
4 important medical information.

5 Review the application carefully before you sign it. Be certain
6 that all information has been properly recorded.”

7 ~~(I) An example showing a physician’s charge, which is equal~~
8 ~~to or less than the allowable limiting charge for the current year,~~
9 ~~of two thousand dollars (\$2,000), the amount that Medicare~~
10 ~~would approve, the amount that Medicare would pay, the amount~~
11 ~~that the policy or certificate would pay, and any amount that~~
12 ~~would be owed by the insured, assuming that the annual~~
13 ~~deductible has already been paid. The statement shall be~~
14 ~~prominently displayed and in type no smaller than other type on~~
15 ~~the page.~~

16 ~~(J)~~ One chart for each benefit plan offered by the insurer
17 showing the services, Medicare payments, payments under the
18 policy and payments expected from the insured, using the same
19 uniform format and language. No more than four plans may be
20 shown on one page. Include an explanation of any innovative
21 benefits in a manner approved by the commissioner.

22 *(m) An issuer shall comply with all notice requirements of the*
23 *Medicare Prescription Drug, Improvement, and Modernization*
24 *Act of 2003 (P.L. 108-173).*

25 SEC. 28. Section 10192.18 of the Insurance Code is amended
26 to read:

27 10192.18. (a) Application forms shall include the following
28 questions designed to elicit information as to whether, as of the
29 date of the application, the applicant *currently* has ~~another~~
30 Medicare supplement, *Medicare Advantage, Medi-Cal coverage,*
31 ~~or other another~~ health insurance policy or certificate in force or
32 whether a Medicare supplement policy or certificate is intended
33 to replace any other disability policy or certificate presently in
34 force. A supplementary application or other form to be signed by
35 the applicant and agent containing those questions and statements
36 may be used.

“(Statements)”

(1) You do not need more than one Medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medi-Cal and may not need a Medicare supplement policy.

~~The~~ *If after purchasing this policy you become eligible for Medi-Cal, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, your suspended Medicare supplement policy or if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days of losing Medi-Cal eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.*

(5) If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare supplement policy or if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug

1 coverage, but will otherwise be substantially equivalent to your
2 coverage before the date of the suspension.

3 (6) Counseling services are available in ~~your~~ *this* state to
4 provide advice concerning your purchase of Medicare
5 supplement insurance and concerning medical assistance through
6 the Medi-Cal program, including benefits as a qualified Medicare
7 beneficiary (QMB) and a specified low-income Medicare
8 beneficiary (SLMB). If you want to discuss buying Medicare
9 supplement insurance with a trained insurance counselor, call the
10 California Department of Insurance's toll-free telephone number
11 1-800-927-HELP, and ask how to contact your local Health
12 Insurance Counseling and Advocacy Program (HICAP) office.
13 HICAP is a service provided free of charge by the State of
14 California.

15
16 (Questions)
17

18 *If you lost or are losing other health insurance coverage and*
19 *received a notice from your prior insurer saying you were*
20 *eligible for guaranteed issue of a Medicare supplement*
21 *insurance policy or that you had certain rights to buy such a*
22 *policy, you may be guaranteed acceptance in one or more of our*
23 *Medicare supplement plans. Please include a copy of the notice*
24 *from your prior insurer with your application. PLEASE*
25 *ANSWER ALL QUESTIONS.*

26 *[Please mark Yes or No below with an "X."]*

27 To the best of your knowledge,

28 ~~(1) Do you have another Medicare supplement policy or~~
29 ~~certificate in force, including an HMO contract?~~

30 ~~(a) If so, with which company?~~

31 ~~(b) If so, do you intend to replace your current Medicare~~
32 ~~supplement policy with this policy or certificate?~~

33 ~~(2) Do you have any other health insurance coverage that~~
34 ~~provides benefits similar to this Medicare supplement policy?~~

35 ~~(a) If so, with which company?~~

36 ~~(b) What kind of policy?~~

37 ~~(c) Would the benefits duplicate the benefits in this Medicare~~
38 ~~supplement policy?~~

39 ~~(3) Are you covered for medical assistance through the~~
40 ~~Medi-Cal program?~~

- 1 ~~(a) As a specified low-income Medicare beneficiary (SLMB)?~~
2 ~~(b) As a qualified Medicare beneficiary (QMB)?~~
3 ~~(c) For other Medi-Cal medical benefits?"~~
4

5 (1) (a) Did you turn 65 years of age in the last 6 months?

6 Yes _____ No _____

7 (b) Did you enroll in Medicare Part B in the last 6 months?

8 Yes _____ No _____

9 (c) If yes, what is the effective date? _____

10 (2) Are you covered for medical assistance through
11 California's Medi-Cal program?

12 NOTE TO APPLICANT: If you have a share of cost under the
13 Medi-Cal program, please answer NO to this question.

14 Yes _____ No _____

15 If yes,

16 (a) Will Medi-Cal pay your premiums for this Medicare
17 supplement policy?

18 Yes _____ No _____

19 (b) Do you receive benefits from Medi-Cal OTHER THAN
20 payments toward your Medicare Part B premium?

21 Yes _____ No _____

22 (3) (a) If you had coverage from any Medicare plan other
23 than original Medicare within the past 63 days (for example, a
24 Medicare Advantage plan or a Medicare HMO or PPO), fill in
25 your start and end dates below. If you are still covered under this
26 plan, leave "END" blank.

27 START __/__/__ END __/__/__

28 (b) If you are still covered under the Medicare plan, do you
29 intend to replace your current coverage with this new Medicare
30 supplement policy?

31 Yes _____ No _____

32 (c) Was this your first time in this type of Medicare plan?

33 Yes _____ No _____

34 (d) Did you drop a Medicare supplement policy to enroll in
35 the Medicare plan?

36 Yes _____ No _____

37 (4) (a) Do you have another Medicare supplement policy in
38 force?

39 Yes _____ No _____

1 (b) If so, with what company, and what plan do you have
2 [optional for Direct Mailers]?

3 Yes _____ No _____

4 (c) If so, do you intend to replace your current Medicare
5 supplement policy with this policy?

6 Yes _____ No _____

7 (5) Have you had coverage under any other health insurance
8 within the past 63 days? (For example, an employer, union, or
9 individual plan)

10 Yes _____ No _____

11 (a) If so, with what companies and what kind of policy?

12 _____

13 _____

14 _____

15 (b) What are your dates of coverage under the other policy?

16 START ____/____/____ END ____/____/____

17 (If you are still covered under the other policy, leave "END"
18 blank.)

19 (b) Agents shall list any other health insurance policies they
20 have sold to the applicant as follows:

21 (1) List policies sold that are still in force.

22 (2) List policies sold in the past five years that are no longer in
23 force.

24 (c) In the case of a direct response issuer, a copy of the
25 application or supplemental form, signed by the applicant, and
26 acknowledged by the issuer, shall be returned to the applicant by
27 the issuer upon delivery of the policy.

28 (d) Upon determining that a sale will involve replacement of
29 Medicare supplement coverage, any issuer, other than a direct
30 response issuer, or its agent, shall furnish the applicant, prior to
31 issuance for delivery of the Medicare supplement policy or
32 certificate, a notice regarding replacement of Medicare
33 supplement coverage. One copy of the notice signed by the
34 applicant and the agent, except where the coverage is sold
35 without an agent, shall be provided to the applicant and an
36 additional signed copy shall be retained by the issuer as provided
37 in Section 10508. A direct response issuer shall deliver to the
38 applicant at the time of the issuance of the policy the notice
39 regarding replacement of Medicare supplement coverage.
40

(e) The notice required by subdivision (d) for an issuer shall be in the form specified by the commissioner, using, to the extent practicable, a model notice prepared by the National Association of Insurance Commissioners for this purpose. The replacement notice shall be printed in no less than 10-point type in substantially the following form:

[Insurer's name and address]

NOTICE TO APPLICANT ~~PLANNING TO REPLACE~~
REGARDING REPLACEMENT OF MEDICARE
SUPPLEMENT COVERAGE OR MEDICARE ADVANTAGE

SAVE THIS NOTICE! IT MAY BE IMPORTANT IN THE FUTURE.

If you intend to cancel or terminate existing Medicare supplement *or Medicare Advantage* insurance and replace it with coverage issued by [company name], please review the new coverage carefully and replace the existing coverage ONLY if the new coverage materially improves your position. DO NOT CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

If you decide to purchase the new coverage, you will have 30 days after you receive the policy to return it to the insurer, for any reason, and receive a refund of your money.

If you want to discuss buying Medicare supplement ~~insurance~~ *or Medicare Advantage coverage* with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

STATEMENT TO APPLICANT FROM THE INSURER AND AGENT: I have reviewed your current health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction does not duplicate coverage. In addition, the replacement coverage contains benefits

1 that are clearly and substantially greater than your current
2 benefits for the following reasons:

- 3 ___ Additional benefits that are: _____
4 ___ No change in benefits, but lower premiums.
5 ___ Fewer benefits and lower premiums.
6 ___ *Plan has outpatient prescription drug coverage and*
7 *applicant is enrolled in Medicare Part D.*
8 ___ *Disenrollment from a Medicare Advantage plan. Reasons*
9 *for disenrollment:*
10 ___ Other reasons specified here: _____

11
12 DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU
13 HAVE RECEIVED YOUR NEW POLICY AND ARE SURE
14 THAT YOU WANT TO KEEP IT.

15
16
17 _____
18 (Signature of Agent, Broker, or Other Representative)

19 _____
20 (Signature of Applicant)

21 _____
22 (Date)
23

24 (f) No issuer, broker, agent, or other person shall cause an
25 insured to replace a Medicare supplement insurance policy
26 unnecessarily. In recommending replacement of any Medicare
27 supplement insurance, an agent shall make reasonable efforts to
28 determine the appropriateness to the potential insured.

29 (g) *An issuer shall not require or request health information*
30 *from an applicant who is guaranteed issuance of any Medicare*
31 *supplement coverage.*

32 SEC. 29. Section 10192.20 of the Insurance Code is amended
33 to read:

34 10192.20. (a) An issuer, directly or through its producers,
35 shall do each of the following:

36 (1) Establish marketing procedures to ensure that any
37 comparison of policies by its agents or other producers will be
38 fair and accurate.

39 (2) Establish marketing procedures to ensure that excessive
40 insurance is not sold or issued.

1 (3) Display prominently by type, stamp, or other appropriate
2 means, on the first page of the policy, the following:

3
4 “Notice to buyer: This policy may not cover all of your
5 medical expenses.”

6
7 (4) Inquire and otherwise make every reasonable effort to
8 identify whether a prospective applicant for a Medicare
9 supplement policy already has health insurance and the types and
10 amounts of that insurance.

11 (5) Establish auditable procedures for verifying compliance
12 with this subdivision.

13 (b) In addition to the practices prohibited by this code or any
14 other law, the following acts and practices are prohibited:

15 (1) Twisting, which means knowingly making any misleading
16 representation or incomplete or fraudulent comparison of any
17 insurance policies or insurers for the purpose of inducing or
18 tending to induce, any person to lapse, forfeit, surrender,
19 terminate, retain, pledge, assign, borrow on, or convert an
20 insurance policy or to take out a policy of insurance with another
21 insurer.

22 (2) High pressure tactics, which means employing any method
23 of marketing having the effect of or tending to induce the
24 purchase of insurance through force, fright, threat, whether
25 explicit or implied, or undue pressure to purchase or recommend
26 the purchase of insurance.

27 (3) Cold lead advertising, which means making use directly or
28 indirectly of any method of marketing ~~which~~ that fails to disclose
29 in a conspicuous manner that a purpose of the method of
30 marketing is the solicitation of insurance and that contact will be
31 made by an insurance agent or insurance company.

32 (c) The terms “Medicare supplement,” “*Medigap*,” “Medicare
33 Wrap-Around” and words of similar import shall not be used
34 unless the policy is issued in compliance with this article. ~~The~~
35 ~~term “medigap” shall not be used.~~

36 (d) The commissioner each year shall prepare a rate guide for
37 Medicare supplement insurance and Medicare supplement
38 contracts. The commissioner each year shall make the rate guide
39 available on or before the date of the fall Medicare annual open
40 enrollment. The rate guide shall include all of the following for

1 each company that sells Medicare supplemental insurance or
2 Medicare supplement contracts in California:

3 (1) A listing of all the policies, plans ~~A through J~~ to L,
4 *inclusive*, that are available from the company.

5 (2) A listing of all the policies, plans ~~A through J~~ to L,
6 *inclusive*, for Medicare beneficiaries under the age of 65 that are
7 available from the company.

8 (3) The toll-free telephone number of the company that
9 consumers can use to obtain information from the company.

10 (4) Sample rates for each policy listed pursuant to paragraphs
11 (1) and (2). The sample rates shall be for ages 0-65, 65, 70, 75,
12 and 80.

13 (5) The premium rate methodology for each policy listed
14 pursuant to paragraphs (1) and (2). "Premium rate methodology"
15 means attained age, issue age, or community rated.

16 (6) The waiting period for preexisting conditions for each
17 policy listed pursuant to paragraphs (1) and (2).

18 (e) The consumer rate guide prepared pursuant to subdivision
19 (d) shall be distributed using all of the following methods:

20 (1) Through Health Insurance Counseling and Advocacy
21 Program (HICAP) offices.

22 (2) By telephone, using the department's consumer toll-free
23 telephone number.

24 (3) On the department's Internet web site.

25 (4) In addition to the distribution methods described in
26 paragraphs (1) to (3), inclusive, each insurer that markets
27 Medicare supplement insurance or Medicare supplement
28 contracts in this state shall provide on the application form a
29 statement that reads as follows: "A rate guide is available that
30 compares the policies sold by different insurers. You can obtain
31 a copy of this rate guide by calling the Department of Insurance's
32 consumer toll-free telephone number (1-800-927-HELP), by
33 calling the Health Insurance Counseling and Advocacy Program
34 (HICAP) toll-free telephone number (1-800-434-0222), or by
35 accessing the Department of Insurance's Internet web site
36 (www.insurance.ca.gov)."

37 SEC. 30. Section 10192.21 of the Insurance Code is amended
38 to read:

39 10192.21. (a) In recommending the purchase or replacement
40 of any Medicare supplement policy or certificate, an agent shall

1 make reasonable efforts to determine the appropriateness of a
2 recommended purchase or replacement.

3 (b) Any sale of a Medicare supplement ~~coverage policy or~~
4 *certificate* that will provide an individual more than one
5 Medicare supplement policy or certificate is prohibited.

6 (c) *An issuer shall not issue a Medicare supplement policy or*
7 *certificate to an individual enrolled in Medicare Part C unless*
8 *the effective date of the coverage is after the termination date of*
9 *the individual's coverage under Medicare Part C.*

10 SEC. 31. No reimbursement is required by this act pursuant to
11 Section 6 of Article XIII B of the California Constitution because
12 the only costs that may be incurred by a local agency or school
13 district will be incurred because this act creates a new crime or
14 infraction, eliminates a crime or infraction, or changes the
15 penalty for a crime or infraction, within the meaning of Section
16 17556 of the Government Code, or changes the definition of a
17 crime within the meaning of Section 6 of Article XIII B of the
18 California Constitution.